MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10103

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? years

Hospital, institution or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 818 Davis Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Edward Allen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1867

8. AGE: Years: 79 | Months: 5 | Days: 16 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Sutland, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Thomas Talbert Allen

13. Birthplace: Prince George Co., Md.

MOTHER 14. Maiden name: Mary Elizabeth Perkins

15. Birthplace: Prince George Co., Md.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1946 (month) (day) (year)

Cemetery or crematory: Geo. Washington Memorial Cemetery

Location: Legg Rd. Hyattsville, Md

18. Funeral director: J. Luther Walters

Address: 254 Carroll St. S.W. Wash. D.C.

19. Oct 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 1946, at 7 00 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1946 to Oct 26 1946

and that I last saw him alive on Oct 25 1946

	DURATION
Immediate cause of death: Coronary occlusion	Terminal
Due to: Arteriosclerosis	years
Due to:	
Other conditions: Inanition	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A. Hare M.D. M. D. or other

Address: Takoma Park, Md. Date signed 10/26/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
[illegible]

10104

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 21 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County:

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: Navy

3.(a) FULL NAME: BABCOCK, Harry Paul, AMlc USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	24	hrs. min.

9. Birthplace: Penn.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: William Babcock
13. Birthplace: N.Y. (dec)

MOTHER
14. Maiden name: Minnie Brown
15. Birthplace: Pa.

16. Informant: Mo: Mrs. Minnie Babcock
Address: North East, Pa.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10-13-46 (month) (day) (year)

Cemetery or crematory: State Line Cemetery

Location: North East, Pa.

16. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St., NW, Washington, D.C.

19. 13 Oct. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 October 1946, at 11:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 May 1946, to 12 October 1946, and that I last saw him alive on 12 October 1946.

Immediate cause of death	DURATION
Hodgkins Disease	Probably 6 mo.
Due to: Etiology unknown	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. E. Wetzel
F. E. WETZEL, Lt.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-13-46

10/19/46

RECEIVED
OCT 19 1946
BUREAU V 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8240

10105

Reg. Dist. No. 21-0

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 25 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Sligo Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary F. Bean

3.(b) Social Security Number

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Mahlon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1863

8. AGE: Years: 82 | Months: 11 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fabius, W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Brown

13. Birthplace: Fabius, W. Va.

MOTHER

14. Maiden name: Virginia Wise

15. Birthplace: Rive, W. Va.

16. Informant: CLELAND W. COMBS. (Son-in-law)

Address: 616 Sligo Ave - Silver Spring, Md

17. Removal + Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3rd 1946 (month) (day) (year)

Cemetery or crematory: Family

Location: Fabius - Hardy Co. W. Va.

18. Funeral director: Harry Humphrey

Address: Silver Spring, Md

19. Nov. 1 1946 (Date rec'd by registrar) Josephine N. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31, 1946, at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15-1940, to 10-31-1946

and that I last saw h.. alive on 10-31-1946

	DURATION
Immediate cause of death: Acute Coronary Occlusion	36 hours
Due to: Chronic coronary sclerosis with partial occlusion	2 weeks
Due to: Generalized arteriosclerosis	10 yrs.
Other conditions: Enlarged heart, chronic passive congestion of lungs. (Include pregnancy within 3 months of death)	6 years.

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. E. Shoemaker M. D. or other

Address: 8005 Woodbury Dr., Silver Spring, Md. Date signed 10/31/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

We need 11/4/46 Jones

RECEIVED
NOV 5 1946
BUREAU OF M.
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

10106

Reg. Diat. No. 314

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital or institution, street address where death occurred:
908 Silver Spring Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 908 Silver Spring Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: RUDOLPH BENDER, Sr.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ida
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2nd. 1868

8. AGE: Years	Months	Days	If less than one day
78	9	12	..... hrs. ..... min.

9. Birthplace: St. Louis, Mo.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U. S. Goverment
FATHER 12. Name: Rudolph Bender
13. Birthplace: Germany
MOTHER 14. Maiden name: Sophia Kerle
15. Birthplace: Germany
16. Informant: Mrs. Ida Bender
Address: 908 Silver Spring Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-1946 (month) (day) (year)
Cemetery: Fort Lincoln
Location: Prince Georges Co. Maryland
18. Funeral director: Harris Funeral Home
Address: Silver Spring, Md.
19. Oct 14 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 OCTOBER 1946 at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY, 1946, to 14 Oct., 1946 and that I last saw h.. alive on 9 OCTOBER 1946

Immediate cause of death	DURATION
CEREBRAL ACCIDENT	
Due to: ARTERIOSCLEROSIS GENERALIZED	
Due to:	
Other conditions: SENILITY CHRONIC NEPHRITIS	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE
Date of op. —
Autopsy results: NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: T. Marshall Tremilliu Jr. M.D. M. D. or other
Address: 8648 GEORGIA AVE. SILVER SPRING, MD. Date signed 14 Oct. 46

M

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 17 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

10167

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
Bethesda Suburban Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 411 Cummings Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: FLORENCE MAY PARR BETHEA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female (FEMALE)	White	Widowed

6.(b) Name of husband or wife: James K. Bethea

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 9, 1878

8. AGE: Years	Months	Days	If less than one day
68	7	28	..... hrs. ..... min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: William J. Parr
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Duell
15. Birthplace: Virginia

16. Informant: Mrs. Elizabeth B. Dietrich
Address: 411 Cummings Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 7 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem

Location: Washington D.C.

18. Funeral director: The S H Hines Co

Address: 2901-14th St., N.W. D. C.

19. 10 15 19 46 (Date rec'd by registrar) Wm E Dobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1946, at 1A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1946 to Oct. 5 1946; and that I last saw her alive on Oct. 4, 1946

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions: Acute appendicitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Acute suppurative appendicitis Date of op. Sept. 28, 46

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Roy A. Thromley M.D.
M. D. or other

Address: 1803 Fillmore St. Washington D.C. Date signed Oct. 5 '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

10168

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Woodacres (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs

Hospital, Institution, or street address where death occurred: 7215 Cobalt st

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Monty -

City or town: Woodacres (If outside city or town limits, write RURAL and give nearest town)

Street No. 7215 - Cobalt (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Clyde Henry Booth

3.(b) Social Security Number: 232-22-6092

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Booth

8.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Mar 23 1906

8. AGE:

Years	Months	Days	If less than one day
40	6	19	...hrs. ...min.

9. Birthplace: Richland Va (Town, county, and state)

10. Usual occupation: manager of food store

11. Industry or business: grocery

MOTHER FATHER

12. Name: Mead Booth

13. Birthplace: Va

MOTHER

14. Maiden name: Alta Stinson

15. Birthplace: Va

16. Informant: Katherine Booth

Address: 7215 Cobalt St - Woodacres md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/15/46 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Rockville, Md.

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave., Bethesda, [illegible], Md.

19. 10/14 19 46 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 19 46, at 2:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 19 ... to Oct 12 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg md Date signed 10-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
OCT 16 1946
BUREAU OF R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

*10109

Reg. Dist. No. 3-14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred: 8718 Cameron St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8718 Cameron St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Christopher Bradley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	married

6.(b) Name of husband or wife: Josephine E.

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): 17 Sept 1882

8. AGE: Years: 64 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U.S. Govt.

FATHER 12. Name: Patrick Henry Bradley

FATHER 13. Birthplace: new York

MOTHER 14. Maiden name: —

MOTHER 15. Birthplace

16. Informant: Mrs J. E. Bradley

Address: 8718 Cameron St, Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-28-46 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Washington, D.C.

18. Funeral director: Francis Collen

Address: 3821-14th St. N.W. Wash. D.C.

19. Oct 25 (Date rec'd by registrar) 1946 Josephine McHaffie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Oct 1946 at 10.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 24 Oct 1946 and that I last saw him alive on 24 Oct 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1d
Due to: Hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William D. Auf M.D. M. D. or other

Address: Silver Spring Md Date signed: 24 Oct 46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 26 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D) +

CERTIFICATE OF DEATH

10110

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Prince St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: Veteran

3. (a) FULL NAME: Ward (n) Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Norma G. Brown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	0	6		

9. Birthplace: Calif.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: Frank M. Brown
13. Birthplace: Wash., D. C. (dec)

MOTHER
14. Maiden name: Minnie Ward
15. Birthplace: Ill, (dec)

16. Informant: wife: Mrs. Norma G. Brown
Address: 127 Prince St., Alexandria, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-16-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler's & Sons, Inc. Cal.
Address: 1750 Penna. Ave., N. W., Wash., D. C.

19. 10-13 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 Oct. 19 46 at 1:30AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Sept. 19 46, to 13 Oct. 19 46 and that I last saw him alive on 13 Oct. 19 46

Immediate cause of death	DURATION
UREMIA AND SEPTICEMIA	2 wks
Due to OBSTRUCTION OF URETERS, BILATERAL	2 months
Due to CARCINOMA OF RECTUM	2 years
& EXTENSIVE METASTASES	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: INOPERABLE CARCINOMA OF RECTUM; HYDRONEPHROSIS Date of op. OCT. 4, 1946

Autopsy results: CA OF RECTUM & GENERALIZED METASTASES

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. E. FITZGERALD, Lt.(jg)(MC)USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-13-46

OCT 19 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10111

Reg. Dist. No. 7-16

1. PLACE OF DEATH:
County: Montgomery
City or town: West Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: West Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 321 Dorset Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Maude Rowland Browne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Browne
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20th 1871

8. AGE: Years	Months	Days	If less than one day
75	2	18	hrs. min.

9. Birthplace: Huntington W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Dr. George Rowland
13. Birthplace: West, Va.
MOTHER 14. Maiden name: Mary Ann Spencer
15. Birthplace: West Va
16. Informant: Mrs. Harold De Coney
Address 321 Dorset Ave.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 8th 1946 (month) (day) (year)
Cemetery or crematory
Location: Washington D.C.
18. Funeral director: Joseph F Birch's Sons
Address 3054 M St. N.W. Wash. D.C.
19. 10/8 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION Oct 8

20. DATE OF DEATH: Chevy Chase Md 1946 at 12 Noon

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Oct 8 1946
and that I last saw h.. alive on Oct 8 1946

Immediate cause of death	DURATION
Exhaustion	
Due to: Arteriosclerosis generalized	Many Years
Due to: Old Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bradley Hodgkiss MD
M. D. or other
Address 313 W Bradley Lane Date signed 10/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 10 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10112

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 8 days

Hospital, institution, or street address where death occurred:

N.N.M.C. Bethesda, Md.

How long in hospital or institution? 3 Months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 East Bradley Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: Veteran

3. (a) FULL NAME: BURNSIDE, John Lookwood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Wife: Mrs. Cecil Burnside

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 11, 1903

8. AGE: Years	Months	Days	If less than one day
42	11	28	..... hrs. ..... min.

9. Birthplace: New Mexico (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Burnside, John

13. Birthplace: Ill.

MOTHER — 14. Maiden name: Carpenter, Harriet

15. Birthplace: N.M.

16. Informant: Wife: Mrs. Cecil Burnside

Address: 120 East Bradley Lane, Chevy Chase, Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 10-12-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W.W. Chambers

Address: 1400 Chapin St. N.W. Wash. D.C.

19. 10 Oct. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 October 1946 at 8:33 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1946, to 9 Oct. 1946 and that I last saw him alive on 9 October 1946

Immediate cause of death	DURATION
Hodgkins disease	slow course
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Abdominal mass, pleural effusion, ascites

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F.E. CHATARD, Comdr. (MC) USN

Address: USNH Bethesda, Md. M. D. or other

Date signed: 10-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/8/46

RECEIVED
OCT 19 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

10113

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:
26 Hesketh Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Hesketh Street,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Ancil Martin Butler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Albert R. Butler

Deceased 6.(c) If alive, give age ysars

7. Birth date of deceased (mo., day, yr.): December 2, 1864

8. AGE: Years	Months	Days	If less than one day
82	28	5	hrs. min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Rev. Joshua Martin
13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Mary Jane Laslie
15. Birthplace: Georgia

16. Informant: Miss Rita L. Butler
Address: 26 Hesketh St. Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/46 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D. C.

18. Funeral director: W. Reuben Thompkins

Address: 7557 Wisconsin Ave. Bethesda, Md.

19. 10/10 19 46 (Date rec'd by registrar) Wm E Jolles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 19 46 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute myocarditis	½ hr.
Due to Chronic Valvular heart disease	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bernhart M. D.
Dep. Med. Exam. M. D. or other

Address: Smithsburg Md. Date signed: 10-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
OCT 15 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10114

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? (13) Thirteen days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2701 14th Street, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st & 2nd World War

3.(a) FULL NAME: CASTLE, Phillip Petrie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Marie A. Castle
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 19 May 1887

8. AGE: Years	Months	Days	If less than one day
59	5	5	hrs. min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business: War Assets Government
FATHER 12. Name: Phillip Castle
13. Birthplace: Md. (dec)
MOTHER 14. Maiden name: Emily Jane Curly
15. Birthplace: Md. (dec)
16. Informant: wife: Mrs Marie A. Castle
Address: 2701 14 th St. N. W. Wash., D. C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1946 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia
18. Funeral director: S.H. HINES & K.
Address: 2901 14th St. N.W., Washington, D.C.
19. Oct 25 19 46 (Date rec'd by registrar) Mary C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 October 19 46, at 5:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Oct. 1946 19 to 24 Oct. 19 46
and that I last saw him alive on 24 Oct., 19 46

	DURATION
Immediate cause of death: Congestive Heart failure	5 mo.
Due to: Arteriosclerotic heart disease-(Cor. art. sclerosis)	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: not performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson Lt. Cmdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/29/46

RECEIVED
OCT 31 1946
BUREAU V.S.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

★ 10115

Reg. Dist. No. 2430

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or Institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7418 Lynnhurst Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

MRS. ZIDE CHALKER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Mr. James H. Chalker

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 22, 1861

8. AGE: Years	Months	Days	If less than one day
85	7	9	— hrs. — min.

9. Birthplace: Mobile, Alabama
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Lloyd Bowers
13. Birthplace: New Orleans, Louisiana

MOTHER
14. Maiden name: Louise Anna Taulmin
15. Birthplace: Mobile, Alabama

16. Informant: Records - Washington Sanitarium and Hospital
Address: 700 Carroll Avenue, Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4 1946 (month) (day) (year)
Cemetery or ~~crematory~~: Arlington National
Location: Arlington, Va.

18. Funeral director: S. P. Hines Co.
Address: 2901 - 14th St. N.W.

19. Oct 31 1946 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1946, at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 October 1946, to October 31 1946
and that I last saw her alive on October 31 1946

Immediate cause of death	DURATION
Cardiac Decompensation	2 days
Due to Arteriosclerotic heart disease	Unknown
Due to Psychosis, Senile due to above	"
Other conditions Wound Infection Postoperative Rt hip (Include pregnancy within 3 months of death)	Since 14 Oct 46

Major findings of operations: Fracture Comminuted Rt. Femur base of neck Date of op. 14 Oct 46
done

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ 14 Oct 46 Date of: to above
Where did injury occur? Takoma Park (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?) Nursing Home
Means of injury: fell shuffling c a Standard to Injured at work?

23. SIGNATURE: Robert W. Augustine M.D.
M. D. or other
Address: 8248 Georgia Ave Date signed: 31 Oct 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 8 1946
BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

State File No. 16116

Reg. Dist. No. 414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 8434 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No.: 8434 Georgia Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EDWARD LEE CHISWELL

3.(b) Social Security Number: 214-03-3329

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of wife: Naomi North Chiswell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	28	hrs. min.

9. Birthplace: Dickerson, Maryland (Town, county, and state)

10. Usual occupation: Retired bookkeeper

11. Industry or business

FATHER — 12. Name: Edward J. Chiswell

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eva White Allnutt

MOTHER — 15. Birthplace: Maryland

18. Informant: Mrs. Warner E. Pumphrey

Address: 8434 Ga. Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21, 1946 (month) (day) (year)

Cemetery or crematory: Monocacy Cemetery

Location: Beallsville, Maryland

18. Funeral director: Harold Thompson

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Oct 19 (Date rec'd by registrar) 19 46 Josephine M. Schaffe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 19 46, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 46, to Oct 17 19 46

and that I last saw h alive on Oct 17 19 46

Immediate cause of death	DURATION
Acute cardiac dilatation	2 10 mos
Due to: Diabetes mellitus	4 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. B. Waydepp M.D. M. D. or other

Address: 943 Bonifant St. Date signed: 10/19/46

RECEIVED
OCT 22 1946
BUREAU P.E.

Evidence for the change of age and date of birth is shown on

FILM No. 108 NOV 22 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

10117

Reg. Dist. No. 216

M

The correct age

I

MARGIN RESERVED FOR BINDING

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 10-21-'46

Hospital, institution, or street address where death occurred:
Suburban Hosp.-8600 Old Georgetown Rd.

How long in hospital or institution? Since 10-21-46 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Garrett Pk.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Rokeby Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James W. Cleveland

3.(b) Social Security Number 577-07-1262.

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of husband or wife Maude Cleveland

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1893 1892

8. AGE: Years	Months	Days	If less than one day
53	11	25	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation ~~—~~ (Retired)

11. Industry or business

FATHER
12. Name J. Robert Cleveland
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Josephine Kane
15. Birthplace Washington D.C.

16. Informant MRS M. IRENE CLEVELAND

Address 22 ROKEBY AVE GARRETT PARK. MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct. 28-1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln.

Location Prince Georges Co. Maryland.

18. Funeral director Clark & Pumphrey.

Address SILVER SPRING. MD

Rec'd by us

19. 10/30 19 46 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26-46 19 at 11:52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1946 to Oct 26 1946 and that I last saw h.. alive on October 26 1946

Immediate cause of death	DURATION
Hemorrhage from oesophageal varices	6 days
Due to cirrhosis of the liver	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. 10-26-46

Autopsy results Confirmatory

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kenneth Laughlen M.D. M. D., or other

Address Rockville Pike Bethesda Md. Date signed 10-26-46

NOV 1 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-A)

CERTIFICATE OF DEATH

* 10118

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County:

City or town: New York City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Earle Hotel 103 Waverly Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Coleman, Mrs. Roberta Roach

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph M. Coleman

6.(c) If alive, give age: 65? years

7. Birth date of deceased (mo., day, yr.): January 14, 1885

8. AGE: Years	Months	Days	If less than one day
61	9	18	hrs. 44 min.

9. Birthplace: Mansfield, Louisiana
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Arthur Virgil Roach
13. Birthplace: Mansfield, La.

MOTHER
14. Maiden name: Mary Elizabeth Roach
15. Birthplace: Camden, Alabama

16. Informant: Washington Sanitarium and Hospital
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 6, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Mansfield, Louisiana

18. Funeral director: Walker & Walker

Address: 25 Carroll St. N.W. Washington D.C.

19. Oct. 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3 1946, at 12:44 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1946, to Oct 3 1946, and that I last saw h[er] alive on Oct. 2 1946.

Immediate cause of death	DURATION
Arteriosclerotic Hypertensive Heart Disease	1 yr.
Bilateral Pneumonia with	2 days
Due to: Right Pulmonary Infarct	1 week
Phlegmonous gastritis	3 days
Due to: Necrotizing Cholecystitis with Cholelithiasis	
Other conditions: Right Renal Hemorrhage	2 days

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. Joe Kepler Meade, M.D.
M. D. or other

Address: 514 Tulip Ave. Takoma Park, Md. Date signed: 10-3-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 5 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10119

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Travilah, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Travilah, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Travilah, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: PATRICK WILLIAM CONNELLY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Katherine Connelly

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): January 1, 1859

8. AGE: Years	Months	Days	If less than one day
87	9	17	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Patrick Connelly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Mary Katherine Connelly
Address: Travilah, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/20/46 (month) (day) (year)

Cemetery or crematory: Darnestown Church Cemetery

Location: Darnestown, Maryland

18. Funeral director: W. Reuben Crumpton

Address: Rockville, Maryland

19. Oct. 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1946, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8 1946 to October 18 1946

and that I last saw him alive on Oct. 17 1946

Immediate cause of death	DURATION
Carcinoma Stomach	Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. D. Hartley, M. D.
M. D. or other

Address: Rockville, Md. Date signed: 10/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 23 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10120

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 438 Kentucky Avenue, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: COUSINS, William Daniel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mary P. Cousins
6.(c) If alive, give age: yenrs

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	19	hrs. min.

9. Birthplace: Canada
(Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business:
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: wife: Mrs. Mary P. Cousins
Address: 438 Kentucky Avenue, S.E., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-11-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.
19. 11 Oct. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 October 1946 at 1:25 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 October 1946 to 11 Oct. 1946
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Cerebral Meningitis (E. coli)	5 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: Cerebral meningitis; Prostatic abscess; arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

W Thompson
23. SIGNATURE: C. W. THOMPSON, Lt. Cdr. (MC) USNR (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 10-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct title is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/22/46

RECEIVED
OCT 23 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47a)

CERTIFICATE OF DEATH

10121

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/18/46

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 13 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3750 Fordham Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DALTON, Donald Maclean, Captain USN Ret. Active

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Harriet Dalton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-25-93

8. AGE: Years	Months	Days	If less than one day
53	1	19	hrs. min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Edwin Dalton
13. Birthplace: Ohio

MOTHER
14. Maiden name: Julia Fitch
15. Birthplace: Ohio (dec)

16. Informant: Wife: Mrs. Harriet Dalton
Address: 3750 Fordham Road, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-16-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers, Georgia Ave.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 10-14- 46 (Date rec'd by registrar) Mary Charlotte Smith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 October 1946 at 10:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 January 1946 to 14 Oct. 1946 and that I last saw h... im ...alive on 14 October 1946

Immediate cause of death: Epidermoid Carcinoma of lung.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: metastatic spread to lungs, esophagus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

C. M. Murry Jr.

23. SIGNATURE: C. M. MURRY, Jr., Lt. (jg) (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-14-46

RECEIVED
OCT 22 1946
BUSPA S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MD)

CERTIFICATE OF DEATH

Reg. Dist. No. 10122 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 YEARS.
Hospital, Institution, or street address where death occurred:
110 CEDAR AVENUE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 CEDAR AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BEN G. DAVIS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: ANNIE L. DAVIS
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 24, 1866

8. AGE:

Years	Months	Days	If less than one day
80	4	26	..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation: RETIRED - CHIEF CLERK STATE DEPT.
11. Industry or business: U.S. GOV'T.

FATHER
12. Name: SOLOMON DAVIS
13. Birthplace: BOONESBORO, MD.

MOTHER
14. Maiden name: REBECCA FLETCHER
15. Birthplace: BOONESBORO, MD.

16. Informant: MRS. ANNIE L. DAVIS
Address: 110 CEDAR AVE., TAKOMA PARK, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23, 1946. (month) (day) (year)
Cemetery or crematory: GEO. WASH. MEMORIAL CEM.
Location: RIGGS ROAD, HYATTSVILLE, MD. PR. GEO. CO.

18. Funeral director: Dixie Funeral Parlors
Address: 254 Carroll St., Takoma Park D.C.

19. Oct 21 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 19 46 at 10:2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — DURATION: dec'd suddenly
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Off. med Exam. M. D. or other
Address: Gaithersburg Md. Date signed 10-20-46

RECEIVED
OCT 23 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-a

CERTIFICATE OF DEATH

★10123

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Fulton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Jerry LeRoy Deary

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1946

8. AGE: Years | Months | Days: 3 | If less than one day: hrs. min.

9. Birthplace Olney, Montgomery County, Md. (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Carl Leonard Deary

13. Birthplace Pine Grove Mills, Pennsylvania

MOTHER 14. Maiden name Jeannette Leona Craber

15. Birthplace Laurel, Maryland

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25 1946 (month) (day) (year)

Cemetery or crematory Fulton

Location Fulton Md.

18. Funeral director Warren E. Kingsbury

Address Silver Spring Md.

19. 10-24-1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946, at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1946 to October 24 1946 and that I last saw h.i.m. alive on October 24 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days.
Due to Birth injury	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 10/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

RECEIVED
NOV 6 1946
BUREAU
2-3

10124

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months 16 days

Hospital, institution, or street address where death occurred:
U.S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 6 months 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Rhode Island County:

City or town: Edgewood, R.I.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 74 Taft St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2.

3.(a) FULL NAME: DITTMAR, Carl Augusta Y3c V6 USNR Act.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1926

8. AGE: Years	Months	Days	If less than one day
20	8	15	hrs. min.

9. Birthplace: R.I.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Carl Dittmar
13. Birthplace: R.I.

MOTHER
14. Maiden name: Cathleen Garner (dec.)
15. Birthplace: R.I.

16. Informant: Mrs. Louise Dittmar (mother)
Address: 74 Taft St. Edgewood, R.I.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10 - 19--1946 (month) (day) (year)

Cemetery or crematory:

Location: Providence, R.I.

18. Funeral director: W.W. CHAMBERS

Address: 1400 Chapin St. N.W. Wash. D.C.

19. 18 Oct. 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 October 1946, at 6:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946, to 17 Oct. 1946 and that I last saw h... im alive on 17 Oct. 1946

	DURATION
Immediate cause of death: Respiratory failure	6 hrs.
Due to: Metastatic Osteosarcoma	4 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: metastatic osteosarcoma to skull Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: E. N. Weaver

E. N. WEAVER, Lt.(jg) (MC) or USNR

Address: USNH Bethesda Md. Date signed: 10-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/22/46

RECEIVED
OCT 23 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175-C

16125

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 hrs.
Hospital, institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd., Bethesda Md
How long in hospital or institution? 19 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County MONTGOMERY.
City or town R.R. 2 - Spring Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.R. 2
(If rural, give LOCATION)
(a) If veteran, name war

3. (a) FULL NAME OLIVER E DOWNES.

3. (b) Social Security Number 579-05-7026

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED.

6.(b) Name of husband or wife Julia Downes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 6, 1879

8. AGE: Years	Months	Days	If less than one day
67	3	10	..... hrs. ..... min.

9. Birthplace Seneca, Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farming

FATHER
12. Name Morris Downes
13. Birthplace Seneca Maryland

MOTHER
14. Maiden name Elizabeth Berry
15. Birthplace Seneca Maryland

16. Informant THOMAS C DOWNS. JR
Address 4836 N.H. AVE NW. WASH. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof OCT-16-1946 (month) (day) (year)
Cemetery or crematory POTOMAC-
Location POTOMAC - MONTG. CO. MD
18. Funeral director Harmon Humphrey
Address SILVER SPRING - MD

19. 10/15 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH 10-13 1946, at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med. Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Abdominal hemorrhage	
Shock	19 hrs.
Due to perforation of small intestine	
Due to fall from horse	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations same as above
Date of op. 10-13-46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 10-12-46
Where did injury occur? Rockville R-2 Monty Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury fall from horse Injured at work? no

23. SIGNATURE Frank J. Bouchat M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg md Date signed 10-13-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 17 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

Reg. Dist. No. 10129 16

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Oct. 10, 1946

Hospital, institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd.

How long in hospital or institution? since 10-10-'46 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 2829 - 27th St. N.W.
(If rural, give LOCATION)

12.(a) If veteran, name war ✓

3.(a) FULL NAME FRANCIS

Mr Wm. F. Doyle ✓

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife May E. Doyle

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	2	..... hrs. ..... min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation Patent Atty. (Retired)

11. Industry or business

FATHER
12. Name Staughton S. Doyle
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden name Mary Palmer
15. Birthplace Philadelphia, Pa.

16. Informant Mrs. May E Doyle
Address 2829 27th St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/46 (month) (day) (year)

Cemetery or crematory Glenwood Cem

Location .....

18. Funeral director J.F. Hines Co

Address 2901 14th St. N.W.

19. 10-22-46 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1946, at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 9 1946, to Oct. 22 1946

and that I last saw h[illegible] alive on Oct. 22 1946

Immediate cause of death	DURATION
Cardiac failure	2 wks.
Due to Cardio-renal Vascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel Diener, M.D.
M. D. or other

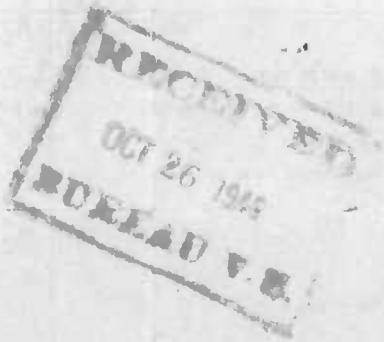
Address 2808 Ordway St. N.W. Wash. D.C. Date signed 10/22/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)


RECEIVED
OCT 26 1945
ROLLA V.E.

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. I 0 8 DEC 17 1946

10127

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
4207 Oakridge Lane,

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207 Oakridge Lane,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: MR. FRANCIS O. DWYER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Brigid McNamara

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 29, ~~1869~~ 1868

8. AGE: Years	Months	Days	If less than one day
77	9	27	..... hrs. ..... min.

9. Birthplace: Williamantic, Conn.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Philip Dwyer
13. Birthplace: Ireland

MOTHER
14. Maiden name: Julia Sheeham
15. Birthplace: Ireland

16. Informant: Mrs. Brigid M. Dwyer
Address: 4207 Oakridge Lane, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington, D. C.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Maryland

19. 10/28/1946 (Date rec'd by registrar) Wm E Julian Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/26/1946, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944, to Oct 1946
and that I last saw him alive on Oct 26 1946

	DURATION
Immediate cause of death — Cerebral Embolism	Instant
Due to: Arteriosclerosis Generalized	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D., or other

Address: 606 Leonard Bldg Date signed 10/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
OCT 29 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 10128 Reg. Dist. No. 723

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Hillandale
(If outside city or town limits, write RURAL and give nearest town)

Street No. PARKMAN RD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ellis, Mr. Charles William

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7, 1880

8. AGE: Years	Months	Days	If less than one day
66	4	15	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Everette Lafayette Ellis
13. Birthplace Petersburg, Virginia

MOTHER
14. Maiden name Sophia Ehrmentraut
15. Birthplace Washington, D.C.

16. Informant Washington Sanitarium & Hospital records
Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1946 (month) (day) (year)

Cemetery or crematory ARLINGTON NAT'L CEMETERY

Location ARLINGTON, VA.

18. Funeral director S. H. Hines Co.

Address 2901 - 14th St. N.W.

19. Oct 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1946, at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10-46 19..., to 10-22-46 19...

and that I last saw him alive on 10-21-46 19...

Immediate cause of death	DURATION
Respiratory Failure	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dean Z. Harding M.D.
M. D. or other

Address 113 Carroll St. NW Washington D.C. Date signed 10-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 23 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10129

Reg. Diat. No. 3-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Brookmont
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: -----

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Brookmont
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6506 - Ridge Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LEE J. EMBREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Catherine Embrey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 12, 1861

8. AGE: Years	Months	Days	If less than one day
85	-	-	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Stanton Glass Embrey
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Olinger
15. Birthplace: Virginia

16. Informant: Mrs. Samuel G. Hamilton - Daughter
Address: 6506 - Ridge Drive, Brookmont, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1946 (month) (day) (year)

Cemetery or crematory: Old Grove Baptist Church Cemetery

Location: GOLD VEIN ..... Virginia

18. Funeral director: Martin W. Hysong Co.

Address: 1300-N Street N.W., Wash. D.C.

19. 10/17/46 (Date rec'd by registrar) Wm E Faber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1946 at 12.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12, 1946 to Oct. 12, 1946 and that I last saw him alive on Oct. 12, 1946

Immediate cause of death	DURATION
Cholecystitis; Myocarditis;	
Chronic myocarditis; over six months	
Due to: Failing Compensation Cor. R.	
Due to: Acute Laryngitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robt. L. Ruedy M. D. or other

Address: 621-Maryland Ave. N.E. Date signed: Oct. 12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 15 1946
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

10130

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

104 Jefferson St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Jefferson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANNIE BELLE FEAGANS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female.	white	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) P.P. 1872.

8. AGE: Years	Months	Days	If less than one day
74	?	?	..... hrs. ..... min.

9. Birthplace Warren Co - Va.

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business —

FATHER

12. Name Richard Feagans.

13. Birthplace Va.

MOTHER

14. Maiden name Nancy Kidwell.

15. Birthplace Va

16. Informant Mrs Sybil H. Gayle.

Address Woodstock - Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4 - 1946 (month) (day) (year)

Cemetery or crematory Massanutten

Location Shenandoah Co Va.

18. Funeral director Wm F Pumphrey.

Address Silver Spring - Md

19. 10-4 1946 (Date rec'd by registrar) Bettyjane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1946, at 6 34 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to October 2 1946

and that I last saw h[illegible] alive on September 25 1946

Immediate cause of death	DURATION
Coronary occlusion	suddenly
Due to Arteriosclerosis	6 yrs to my knowledge
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. D. Hostetter, M.D. M. D. or other

Address Rockville, Md Date signed 10/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

OCT 5 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10131

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 10-5-46

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? since 10-5-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6415 - 31st St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mrs Sarah A Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife William H Fisher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21 - 1871

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace ..... (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm Rady

13. Birthplace Va

MOTHER 14. Maiden name Amelia Powe

15. Birthplace Va

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-17-46 (month) (day) (year)

Cemetery or crematory Glenwood

Location Washington, D.C.

18. Funeral director The L. H. Hines Co.

Address 2401 - 14th St. N.W. D.C.

19. 10/17 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 19 46, at 11.40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 19 46, to October 17 19 46 and that I last saw h[illegible] alive on October 16 19 46

Immediate cause of death	DURATION
Coronary Occlusion	12 days
Due to Coronary artery disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Joseph J McCarthy M. D. or other

Address 3001 Que N.W. Wash D.C. Date signed 10/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

OCT 22 1946
BUREAU V R

10132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg Co
City or town: Near, Gaithersburg-Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Near Travilla, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gaithersburg R F D 3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rodger Walker Fling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Lurline Fling
6.(c) If alive, give age: 24 years
7. Birth date of deceased (mo., day, yr.): Oct 15th 1920

8. AGE: Years	Months	Days	If less than one day
1920 25	11	27	hrs. min.

9. Birthplace: Poolsville, Md,
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business:

FATHER
12. Name: William A Fling
13. Birthplace: Md,

MOTHER
14. Maiden name: Edith Gray
15. Birthplace: Va,

16. Informant: Alice L Fling
Address: Gaithersburg, R F D 3. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/46 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Oct. 15 1946 (Date rec'd by registrar) Abner L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12th 1946 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9th Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) Asthenia due to	during
(b) Strangulation (accidental)	ending
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-12-46
Where did injury occur? Gaithersburg (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Caught in corn cutter Injured at work? Yes

23. SIGNATURE: Frank J. Broschart M. D. (M. D. or other)
Address: Gaithersburg Md Date signed 10-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 17 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-0)+

CERTIFICATE OF DEATH

* 10133

Reg. Dist. No. 214

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eleven days

Hospital, institution, or street address where death occurred:

708 Sligo Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Cabin John, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Garbers, Minnie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: William Garbers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1900.

8. AGE: Years: 46 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Joseph Dempsey

13. Birthplace: ?

MOTHER

14. Maiden name: Emma Smith

15. Birthplace: ?

16. Informant: Helen Garbers

Address: 105 Tomlinson Ave. Cabin John Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 31, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va

18. Funeral director: W. W. Chambers Co.

Address: 3072-M-St. N.W.

19. Oct 29 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1946, at 6 25 a.m., p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18 1946, to Oct 28 1946

and that I last saw her alive on Oct 28 1946

Immediate cause of death	DURATION
Carcinoma of cervix uteri with widespread	
Due to metastases	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer J. Brown M.D.

M. D. or other

Address: 45 Carroll Ave, Takoma Date signed: Oct 29, 1946

RECEIVED
OCT 30 1945
BUREAU OF M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10134

Reg. Diat. No. 261

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 17 days

Hospital, institution, or street address where death occurred:
N.N.M.C. BETHESDA, MD.

How long in hospital or institution? 1 month 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: NEW YORK County:

City or town: Buffalo
(If outside city or town limits, write RURAL and give nearest town)

Street No. 490 LeRoy Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

GEHRES, Albert Daniel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-U.S.	Married

6.(b) Name of husband or wife: Wife: Mrs. A.D. GEHRES

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 26, 1910

8. AGE: Years	Months	Days	If less than one day
36	5	19	hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: USMC

11. Industry or business:

FATHER
12. Name: Albert D. Gehres
13. Birthplace: Germany

MOTHER
14. Maiden name: Nellie Putman
15. Birthplace: N.Y.

16. Informant: Mrs. A.D. Gehres
Address: 490 LeRoy Ave. Buffalo, N.Y.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10-15-46 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Syracuse, N.Y.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W. Washington, D.C.

19. 15 October 1946 (Date rec'd by registrar) M.C. SMITH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 October 1946, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Aug. 1946 to 15 Oct. 1946

and that I last saw him alive on 15 Oct. 1946

	DURATION
Immediate cause of death: Respiratory failure	12 hrs.
Due to: Brain Tumor, malignant, mixed activity, cells	3 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Brain Tumor Date of op. Oct. 14, 1946

Autopsy results: Brain Tumor

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. N. Weaver
E. N. WEAVER, Lt. (jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 10-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10/18/46

RECEIVED
OCT 22 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

10135

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ----

Hospital, Institution, or street address where death occurred:

1918 Luzerne Avenue

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 1918 Luzerne Avenue (If rural, give LOCATION)

2.(a) If veteran, name war ----

3.(a) FULL NAME CAROLA GIOVANNONI

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~ Angelo J. Giovannoni

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1871

8. AGE: Years 75 | Months 7 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Jacondo Giovannetti

13. Birthplace Italy

MOTHER 14. Maiden name Lucia DeMarchi

15. Birthplace Italy

16. Informant Angelo J. Giovannoni

Address 1918 Luzerne Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1946 (month) (day) (year)

Cemetery ~~or crematory~~ CEDAR HILL CEMETERY (Crypt)

Location Suitland, Prince Geo. Co., Md.

18. Funeral director Warren E. Pumphrey

Address 8434 Ga. Ave., Silver Spring, Md.

19. Oct 27 1946 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1946, at 3:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1946, to 10/22 1946 and that I last saw h--- alive on 10/22 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	7 days
Due to Hypertensive Heart disease	6 mos.
Due to Generalized Arteriosclerosis	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. A. Leonardi M.D. M. D. or other

Address 5801-13th St. N.W. Date signed 10/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
OCT 26 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10136

Reg. Diat. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: Sligo Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D C County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2518 - 33 - st SE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EFFIE M. Gochenour

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow.

6.(b) Name of husband or wife: Wm. P.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1866

8. AGE: Years: 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Altenvis (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Daniel Stout
13. Birthplace: Pa.

MOTHER — 14. Maiden name: Mary Curtis
15. Birthplace: Ohio

16. Informant: Mrs Wm H Fox
Address: 4215 - 13 St. N.E.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Oct. 17 1946 (month) (day) (year)
Cemetery or crematory: Glenwood Cem. Wash DC
Location:

18. Funeral director: Wm. Lee's Sons Co.
Address: 300 - 4th St. N.W. Washington DC

19. Oct 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1946, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1945 to Oct 14 1946
and that I last saw her alive on Oct 14 1946

Immediate cause of death	DURATION
Hypertensive heart dis.	2 yrs
Due to	
Due to	
Other conditions: Infectious cervical adenitis (undetermined infection)	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Andrews M.D.
M. D. or other
Address: Silver Spring Md Date signed: 10-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 17 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 10216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

6317 Delaware st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6317 Delaware st.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ADELBERT R. GORDON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma C. Gordon

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1869

8. AGE: Years: 77 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Adelbert R. Gordon

13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Bessie Laws

15. Birthplace: Lynchburg, Va.

16. Informant: Harry D. Gordon

Address: 6408 Fulton st, Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1946 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Washington, D.C.

18. Funeral director: The R.H. Nines Co.

Address: 2901-14th st, N.W., Wash. D.C.

19. 10/11 1946 Mr E Jaber Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 1946, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1944 to Oct. 11 1946

and that I last saw him alive on Oct. 11 1946

	DURATION
Immediate cause of death: Coronary Occlusion	?
Due to: Embolus	?
Due to: Hypertension	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard A. Craft M.D. M. D. or other

Address: 3109 - 16th St NW Date signed: 10/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 15 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 10138 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Burtonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Burtonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Gore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: James Wayman Gore

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Sept. 3 1868

8. AGE: Years	Months	Days	If less than one day
78	1	6	hrs. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Newton Baggarley

13. Birthplace: Va.

MOTHER 14. Maiden name: Susan Brown

15. Birthplace: Va.

16. Informant: Alice Beall

Address: Burtonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1946 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Burtonsville Md.

18. Funeral director: De Witt Donaldson

Address: Laurel, Md.

19. Oct 10 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

(Burial Permit issued at Laurel, Md.)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1946, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Oct 9 1946 and that I last saw her alive on Oct 8 1946

Immediate cause of death	DURATION
Myocardial Failure	1 wk.
Due to: Multiple Sclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J M Warren M D
M. D. or other

Address: Laurel Date signed 10-9-46

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 18 1946
BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

★ 10139

Reg. Dist. No. 216/

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County:

City or town: Mt. Clare
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd World War

3.(a) FULL NAME: GRAVES, Roy Mark

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-3-24

8. AGE: Years	Months	Days	If less than one day
22	8	28	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: U.S. Marine Corps

11. Industry or business:

FATHER
12. Name: Roderick P. Graves
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Audrey Kennedy
15. Birthplace: West Virginia

16. Informant: Clarence E. Graves (brother)
Address: Rt. #1 Mt. Clare, West, Va.

17. removal & burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 1946 (month) (day) (year)

Cemetery or crematory: Stonewall Park

Location: Clarksburg, West Va.

18. Funeral director: W.W. CHAMBERS

Address: 1400 Chapin St. N.W., Washington, D.C.

19. Oct. 31, 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31, 1946 19 at 1545 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4 19 46 to Oct. 31 19 46 and that I last saw him alive on Oct. 31 19 46

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D.W. Mulder D.W. MULDER Lt. (jg) (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11/5/46

RECEIVED
NOV 6 1946
BUREAU V S

1-25

L-2160

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a)

CERTIFICATE OF DEATH

10140

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 22 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Okla. County:

City or town: Claremore
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 86
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

HALL, Ruth Maxine, Lt. Cdr. USNWR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1903

8. AGE: Years	Months	Days	If less than one day
43	2	1	hrs. min.

9. Birthplace: Okla.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: William M. Hall
13. Birthplace: Mo.

MOTHER
14. Maiden name: Eva Alice Rogers
15. Birthplace: Kansas

16. Informant: Fa: Mr. William M. Hall

Address: Box 86, Claremore, Okla.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10-16-46 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Claremore, Okla

18. Funeral director: W. W. Chambers RWB.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 10-16 (Date rec'd by registrar) 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 October 19 46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 April 19 46, to 16 Oct. 19 46

and that I last saw him alive on 16 Oct. 19 46

	DURATION
Immediate cause of death: Carcinoma Ovaries & Omentum	5 months
Due to: Exenteration	1 Month
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of ovaries & omentum

Date of op. June 1946

Autopsy results: Metastasis to all abdominal organs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Peterson
Paul Peterson, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/18/46

RECEIVED
OCT 22 1946
BUREAU V S

10141

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-D 1

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 4 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Canada County:
City or town: Toronto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 139 Quebec Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HAMILTON, Jane E.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1877

8. AGE: Years	Months	Days	If less than one day
69	0	8	hrs. min.

9. Birthplace: Canada
(Town, county, and state)
10. Usual occupation: retired Navy Nurse
11. Industry or business:

FATHER
12. Name: William Hamilton
13. Birthplace: Md. (dec)

MOTHER
14. Maiden name: Elizabeth A. Hook
15. Birthplace: Md. (dec)

16. Informant: brother: Mr. Thomas R. Hamilton
Address: 139 Quebec Avenue, Toronto, Canada

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-9-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetary
Location: Arlington, Virginia
18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St., NW, Wash., D.C.

19. 10-4 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 19 46 at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 April 19 46, to 4 Oct. 1946 and that I last saw her alive on 4 October 1946

Immediate cause of death	DURATION
Adenocarcinoma, recto-sigmoid	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. C. Owens
J. C. OWENS, Lt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

10/22/46

RECEIVED
OCT 23 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10142

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 years

Hospital, institution, or street address where death occurred:

10406 Old Bladensburg Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural, Silver Spring

(If outside city of town limits, write RURAL and give nearest town)

Street No. 10406 Old Bladensburg Rd.

(If rural, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME: John Frederick Hamilton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Elizabeth Case

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): January 3, 1877

8. AGE:

Years	Months	Days	If less than one day
69	9	1	hrs. min.

9. Birthplace: Four Corners Montgomery, Md.
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Naval Research, U.S.A.

FATHER

12. Name: John Alexander Hamilton

13. Birthplace: Louisanna, U.S.A.

MOTHER

14. Maiden name: Mary Elizabeth Free

15. Birthplace: Four Corners Montgomery, Md.

16. Informant: Mrs. Mary E. Hamilton

Address: 10406 Old Bladensburg Rd. Silver Sp. Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: OCT 7 1946 (month) (day) (year)

Cemetery or crematory: COLESVILLE

Location: COLESVILLE - MONT. Co

18. Funeral director: James E. Pumphrey

Address: SILVER SPRING - MD.

19. Oct 6 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1946 to Oct. 3, 1946

and that I last saw h.. alive on October 3, 1946

	DURATION
Immediate cause of death: Malnutrition and Acidosis	6 wks.
Due to: Portal Obstruction	10 wks.
Due to: Carcinoma of Pancreas	5 mo.+
Other conditions: Lues, Tertiary	years

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Pancreas with Metastasis to Mesentery. Date of op. Aug 4 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Wallace Z. Woodward M. D. or other

Address: 805 Carroll Ave. Takoma Park Md. Date signed: 10-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
OCT 9 1946
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-6)

CERTIFICATE OF DEATH

★ 10143

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if it is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11/5/46

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 27 days
Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland
How long in hospital or institution? 6 months 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 606 Potomic Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd World War

3.(a) FULL NAME: HANEKAMP, George Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Margaret Hanekamp
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 7-18-07

8. AGE:	Years	Months	Days	If less than one day
	39	3	13	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: VAP
11. Industry or business
FATHER 12. Name: William Hanekamp
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Holder
15. Birthplace: Maryland
16. Informant: Mrs. Margaret Hanekamp
Address: 606 Potomic Ave., Alexandria, Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/4/46 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Alexandria, Virginia
18. Funeral director: W.W. CHAMBERS (UM)
Address: Washington, D.C.
19. Oct. 31 1946 (Date rec'd by registrar) Marylouise Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1946 at 1730 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1946 to October 31 1946 and that I last saw him alive on October 31 1946

Immediate cause of death	DURATION
Bronchopneumonia (Postoperative)	4 days
Due to: Vagotomy	4 days
Due to:	
Other conditions: Gastro-enterostomy following duodenal Ulcer (Include pregnancy within 3 months of death)	4 yrs

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F.S. ASHBURN LT.CMDR.(MC)USN (M. D. or other)
Address: USNH Bethesda, Maryland Date signed: Oct.31,46

RECEIVED
NOV 6 1946

1-25

2-2160

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

10144

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5514 Hampden Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Gertrude Hendricks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Homer R. Hendricks
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 28, 1904

8. AGE: Years	Months	Days	If less than one day
42	6	4	...hrs. ...min.

9. Birthplace: Berwick, Pa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John F. Bogart
13. Birthplace: Benton, Township, Pa.

MOTHER
14. Maiden name: Anna May Williams
15. Birthplace: Jackson, Twonship, Pa.

16. Informant: Mr. John F. Bogart
Address: 1018 West Front Street, Berwick, Pa.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 10/3/46 (month) (day) (year)
Cemetery or crematory: Pine Grove Cemetery
Location: Berwick, Pa.

18. Funeral director: W Rubrey Dunphrey
Address: 7557 Wisconsin Ave. Bethesda, Md.

19. Oct 3 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 / 2 / 1946, at 5a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem 19..., to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Intra cranial Hemorrhage due to Gunshot wound	
Due to: Accidental Shot	
Due to: Bullet wounds	
Due to:	
Other conditions: Multiple Fibromyomas 7 uterus, Tall obese	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 10/2/46
Where did injury occur? Bethesda (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Bullet wounds Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Gaithersburg Md Date signed 10/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 7 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10145

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:
7729 Old Georgetown Rd.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7729 Old Georgetown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Dr. Timothy Glenn Hetrick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence S. Hetrick

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): September 15, 1904

8. AGE: Years	Months	Days	If less than one day
42	1	14	___ hrs. ___ min.

9. Birthplace: Du Bois, Pa.
(Town, county, and state)

10. Usual occupation: Chiropractor

11. Industry or business: Above

FATHER — 12. Name: Ord Hetrick

FATHER — 13. Birthplace: Penn.

MOTHER — 14. Maiden name: Blanche Schumaker

MOTHER — 15. Birthplace: Penn.

16. Informant: Mrs. Jules A. Halluin

Address: 2352 Neb. Ave. N.W., Wash., D.C.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1946 (month) (day) (year)

Cemetery or crematory: Du Bois Cemetery

Location: Du Bois, Pa.

18. Funeral director: Wm. Rawdon Dunphey

Address: Bethesda, Maryland

19. 10/31 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1946, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — DURATION: Found dead in home

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D.
Dep. Med. Exam. M. D. or other

Address: Hagerstown, Md. Date signed: 10-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
NOV 2 1946
BUREAU V A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 10146 23

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

911- Grandin Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 911 Grandin Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Dallas William Hutchinson

3.(b) Social Security Number 215-14-6645

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Beulah E. Hutchinson

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 29 1878

8. AGE: Years 68 | Months 6 | Days 6 | If less than one day .....hrs. .....min.

9. Birthplace Montgomery Co - Maryland (Town, county, and state)

10. Usual occupation Watchman

11. Industry or business Natl Institute of Health

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Lucinda Riggs

15. Birthplace Maryland

16. Informant Mrs Beulah E. Hutchinson (wife)

Address 911- Grandin Ave Rockville Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct 8/46 (month) (day) (year)

Cemetery or crematory Colesville Friends Cem

Location Colesville - Maryland

18. Funeral director Wm. Reuben Trumbauer

Address Rockville - Maryland

19. 10-9 (Date rec'd by registrar) 19 46 Lucian Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 19 46, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 41, to Oct 5 19 46

and that I last saw him alive on Oct 2 19 46

Immediate cause of death	DURATION
Congestive heart failure (Patient found dead after being seen fairly comfortable one hour previously)	
Due to Arteriosclerotic heart disease	6 years
Other conditions Episodes of congestive failure for 6 years, most recent 3 days prior to death.	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Willa Hall M.D.

Address Rockville M. D. or other

Date signed Oct 7, 1946

RECEIVED
OCT 11 1946
BUREAU V S

10147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Danville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 Halifax Street,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JEFFERSON, James D.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Anna Jefferson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	16	hrs. min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: veteran
11. Industry or business

FATHER
12. Name: Joe Howell Jefferson
13. Birthplace: Va. (dec)

MOTHER
14. Maiden name: Lillie ?
15. Birthplace: Va.

16. Informant: wife: Mrs. Anna Jefferson
Address: 125 Halifax St., Danville, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 10-21-46 (month) (day) (year)
Cemetery or crematory:
Location: Danville, Va.
18. Funeral director: W. W. CHAMBERS, L E.J.J
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 10-19 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 October 19 46, at 9:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 October 19 46, to 19 Oct. 19 46 and that I last saw h... im alive on 19 Oct. 19 46

	DURATION
Immediate cause of death: Pneumonia,	2 days
Due to: Brain Tumor; malignant; mixed activity. Cyst. R.	3 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

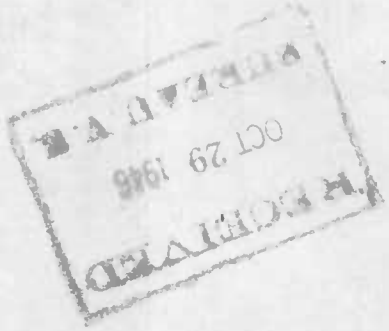
E. N. Weaver
23. SIGNATURE: E. N. WEAVER, Lt.(jg)(MC) USNR M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10/26/46


RECEIVED
OCT 29 1946
CLEVELAND, O.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10148

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wash., D.C. County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 426 Vee St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew BARKER JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-19-98

8. AGE: Years	Months	Days	If less than one day
47	10	13	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER — 12. Name: William BARKER JOHNSON (Dec.)

FATHER — 13. Birthplace: Wash, D.C.

MOTHER — 14. Maiden name: Ann (unknown) (Dec.)

MOTHER — 15. Birthplace: Maryland

16. Informant: BrotherB Claude Barker Johnson

Address: 426 Vee St. NW. Wash, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-7-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Barbour Bros.

Address: 48 K. St. N.E. Wash, D.C.

19. 3 Oct. 1946 (Date rec'd by registrar) Mary Charlotte Smith, M.C. SMITH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 October 1946 at 3:33 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Sept. 1946 to 2 Oct. 1946 and that I last saw him alive on 2 Oct. 1946

Immediate cause of death	DURATION
Thrombosis coronary artery	8 days
Due to Coronary artery sclerosis	years
other condi: Syphilis, hyperten. diabetes mellitus, hemorrhaging gastric ulcer, chronic	
Other conditions: Glomerular nephritis, pulmonary embolis, cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson Lt. Cdr. M.(MC) USNR

Address: USNH Bethesda, Md. Date signed: 10-2-46

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/12/46

RECEIVED
OCT 15 1946
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10149

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1129 Park Pl. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish Amer.-World War I

3.(a) FULL NAME: JUDY, Paul Hedrick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W US	married

6.(b) Name of husband or wife: Mrs. Sarah Judy

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 2 1875

8. AGE: Years	Months	Days	If less than one day
71	6	27	...hrs. ...min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: VAP

11. Industry or business:

FATHER
12. Name: John Judy
13. Birthplace: Ohio

MOTHER
14. Maiden name: Sarah Hedrick
15. Birthplace: Ohio

16. Informant: Wife: Mrs. Sarah Judy
Address: 1129 Park Pl. N.E. Washington, D.C.

17. Burial (Burial, cremation, or removol. Which?) Date thereof Nov. 1, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: J. Wm. Lee Sons & Emmick

Address: 3004 4th St NE D.C.

19. Oct 29, 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29 1946 at 1435 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Oct 29 1946 and that I last saw h... alive on Oct 29 1946

Immediate cause of death	DURATION
Acute Coronary thrombosis	
Due to: Uremia: direct prostatic obstruction	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: R.E. FITZGERALD Lt.(jg)(MC)USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: Oct 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11/5/46

RECEIVED
NOV 6 1946
BUREAU V S.

1-25

2-2160

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10150

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Montgomery

City or town: Rockville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred: 300 - Reading Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Rockville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 300 - Reading Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mr. Carey Kingdon

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	M Married

6.(b) Name of husband or wife: Hattie C. Kingdon

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): August 9-1872

8. AGE: Years: 74 | Months: 1 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Kingstown - Wash. DC. (Town, county, and state)

10. Usual occupation: News Reporter

11. Industry or business: Washington County Star

FATHER

12. Name: John Kingdon

13. Birthplace: West Indies

MOTHER

14. Maiden name: Alvinda Appler

15. Birthplace: Unknown

16. Informant: Mrs. Hattie C. Kingdon

Address: 300 - Reading Ave - Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8-1946 (month) (day) (year)

Cemetery or crematory: St. Mary's Catholic Cem -

Location: Nr - Rockville - Maryland

18. Funeral director: W. M. Rubin Humphrey

Address: Rockville - Maryland

19. (Date rec'd by registrar) 10-9-1946 Luther Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 1946 to Oct 6 1946 and that I last saw him alive on Oct 6 1946

	DURATION
Immediate cause of death: Carcinoma of rectum	10 mos
Due to:	
Due to:	
Other conditions: Cerebral hemorrhage	1 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. E. Hawks M. D. or other

Address: Rockville Md Date signed: 10/7/46

RECEIVED
OCT 11 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7) 1

10151

CERTIFICATE OF DEATH

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Dickerson (If outside city or town limits, write RURAL and give nearest town) Dist No 6
How long in above place of death? 6 mo
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Boyds (Rural) (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #2 - Boyds (If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Elizabeth May Larman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James Larman
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): May 17 - 1861

8. AGE: Years	Months	Days	If less than one day
85	5	13	..... hrs. ..... min.

9. Birthplace: Boyd, Montg. Co Md (Town, county, and state)
10. Usual occupation: House-Wife
11. Industry or business
FATHER 12. Name: Nelson Thompson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Knott
15. Birthplace: Maryland
16. Informant: Mrs Anna Morningstar
Address: Dickerson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2 - 1946 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville / Md
18. Funeral director: William B. Hilton
Address: Barnesville, Md
19. Oct. 31 1946 (Date rec'd by registrar) Mrs. C. C. Hilton by Mrs. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30. 1946, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15. 1946 to Oct 30. 1946 and that I last saw h.. alive on Oct 29. 1946 (17 PM)

Immediate cause of death	DURATION
Carcenomata of Liver and Gall bladder	9 mo
Due to: Asthenia (Myocarditis Sub-acute)	
Due to: Arterial sclerosis	20 yrs
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Victor D. Towne M.D
Address: P.O. Boyds Dairon, Md. M.D. or other
Date signed: Oct 30/46

RECEIVED
NOV 4 1946
BERLAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10152

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Sept. 17, 1941

Hospital, institution, or street address where death occurred:
Chestnut Lodge Sanitarium

How long in hospital or institution? Since Sept. 17, 1941

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 Montgomery Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Miss Minnie R. Leonori

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 12, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	28	____ hrs. ____ min.

9. Birthplace: Astoria, Long Island, New York
(Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business:

FATHER
12. Name: Robert Henry Leonori
13. Birthplace: Brooklyn, N. Y.

MOTHER
14. Maiden name: Fountain, Phebe Jane
15. Birthplace: New York City, N. Y.

16. Informant: Sister: Mrs. Adelaide McIntyre
Address: 20 Large Ave., Hillsdale, N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1946 (month) (day) (year)

Cemetery or crematory: Green-Wood Cemetery

Location: Brooklyn, N. Y.

18. Funeral director: W. Reuben Tumphrey

Address: 7557 Wis. Ave., Bethesda, 14, Md.

19. Oct. 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1941, to Oct. 10, 1946 and that I last saw her alive on Oct. 10 1946

Immediate cause of death	DURATION
pneumonia, lobular	3 days
Due to: Advanced senile cachexia	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: Alfred A. Stanton, M.D.
M. D. or other

Address: Rockville, Md. Date signed: Oct. 10, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 15 1946
BUREAU OF M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-2)

CERTIFICATE OF DEATH

10153

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 10-25-'46

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda Md.

How long in hospital or institution? Since 10-25-'46

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 5308 Moorland Lane (If rural, give LOCATION)

(a) If veteran, name war

3. (a) FULL NAME Mr Thomas Lewis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of husband or wife Elizabeth Lewis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1900

8. AGE: Years	Months	Days	If less than one day
46 46	6	3	— hrs. — min.

9. Birthplace Bethesda, Md. (Town, county, and state)

10. Usual occupation Vice President - H.H. Rust Co.

11. Industry or business " "

MOTHER FATHER

12. Name John Lewis

13. Birthplace Essex Va.

MOTHER

14. Maiden name Mary Chichester

15. Birthplace Fairfax, Va.

16. Informant Elizabeth C. Lewis

Address 5308 Moorland Lane 10/29/46

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/46 (month) (day) (year)

Cemetery or crematory Alexia Church Cemetery

Location Fredericksburg Va.

18. Funeral director Wm Reuben Humphrey

Address Bethesda, Md.

19. 10/28 19 46 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 19 46 at 9:55 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1945 19.. to October 26 19 46

and that I last saw h.. in alive on October 26 19 46

Immediate cause of death	DURATION
Rupture of Esophageal varicosities	12 hrs
Due to bleeding liver	2 yrs.
Due to	
Other conditions Arterial hypertension	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results Confirming above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Lomax Wells M.D. M. D. or other

Address 2011 R St. N.W. Washington, D.C. Date signed Oct. 26 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

RECEIVED
OCT 29 1965
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

10154

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: GLENMONT
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
GA AVE & COLESVILLE - GLENMONT RDS.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: ASPEN HILL.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R F D - 4 - ROCKVILLE MD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William C. Long

3.(b) Social Security Number 214-03-8158.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: NELLIE MAY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JUNE 17TH 1898

8. AGE: Years	Months	Days	If less than one day
48.	3.	19	hrs. min.

9. Birthplace: VIRGINIA.
(Town, county, and state)
10. Usual occupation: BRICKLAYER
11. Industry or business
FATHER 12. Name: HERBERT LONG
13. Birthplace: VIRGINIA.
MOTHER 14. Maiden name: JENNIE TALLEY
15. Birthplace: VIRGINIA.
16. Informant: MRS. NELLIE MAY LONG.
Address: ASPEN HILL - MD
17. BURIAL. (Burial, cremation, or removal. Which?) Date thereof: OCT. 9 - 1946 (month) (day) (year)
Cemetery or crematory: SHADY GROVE CHURCH.
Location: CHANCELLOR - SPOTSYLVANIA CO VA.
18. Funeral director: Wane E Pumphrey
Address: SILVER SPRING. MD.
19. Oct 7 1946 (Date rec'd by registrar) Josephine M Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1946 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med. Exam case to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Compound fracture of skull	died instantly
Due to: auto accident	
Due to:	
Other conditions: Contusion chest	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 10-6-46
Where did injury occur? Aspen Hill (City or town) Mont (County) Md (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto. accident Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other
Address: Gaithersburg md Date signed: 10-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 9 1946
BUREAU V R

10155

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hr.
Hospital, institution, or street address where death occurred:
1216 Stoplein Dr.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9211 [illegible] Dr.
(Rural, give LOCATION)
2.(a) If veteran, name war OFB

3.(a) FULL NAME James A. Matthews

3.(b) Social Security Number 578-03-5873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife Isabella
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 29th. 1873

8. AGE: Years	Months	Days	If less than one day
72	9	3	..... hrs. ..... min.

9. Birthplace Lomaconing, Md.
(Town, county, and state)
10. Usual occupation Retired Engineer
11. Industry or business Terminal Cold Storage
FATHER 12. Name George Matthews
13. Birthplace Scotland
MOTHER 14. Maiden name Annie Walker
15. Birthplace Scotland
16. Informant George E. Matthews
Address 4000 - 56th. Pl. Hyattsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-5-1946 (month) (day) (year)
Cemetery or crematory Rock Creek
Location Washington, D. C.
18. Funeral director Dove & Pumphrey
Address Silver Spring, Md.
19. Oct 3 (Date rec'd by registrar) 19 46 Josephine M. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 46 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 30 19 46, to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death	
Coronary occlusion	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred J. Broschart M.D.
M. D. or other
Address Gaithersburg Md Date signed 10-2-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

10156

Reg. Dist. No. 223

1. PLACE OF DEATH:
County MONT. Co.
City or town TAKOMA PARK Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10-14-46 TO 10-20-46
Hospital, institution, or street address where death occurred:
TAKOMA PARK SAN.
How long in hospital or institution? SIX DAYS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County MONT
City or town TAKOMA PARK Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 SYCAMORE AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME McGOWAN, ADA B.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

6.(b) Name of husband or wife HARRY J McGOWAN.

7. Birth date of deceased (mo., day, yr.) June 10 1867 / DEC. 79, 1866 (If alive, give age) 79 years

8. AGE: Years	Months	Days	If less than one day
79 75	4	9	hrs. min.

9. Birthplace WASH D.C. (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name JOHN HOFFMAN
13. Birthplace GERMANY - marmadukes

MOTHER 14. Maiden name SUSAN Mamduke
15. Birthplace Va. Stratford

16. Informant HARRY J McGOWAN.
Address 24 SYCAMORE AVE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23, 1946 (month) (day) (year)
Cemetery or crematory Congressional.
Location Washington D.C.

18. Funeral director J. H. Hines CO.
Address 2901-14th St. N.W. Wash. D.C.

19. Oct 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1946, at 8 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1946, to Oct 20 1946
and that I last saw h.e.r. alive on Oct 20 1946.

Immediate cause of death	DURATION
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive Cardiovascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dean W. Harding M.D. M. D. or other
Address 113 Cameron St. N.W. Washington D.C. Date signed 10-20-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 23 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

Reg. Dist. No. 10157 3/14

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
708 Sligo Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 Sligo ave Silver Spring Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie Louisa Meitzler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm Meitzler

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 12, 1870

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Lockport N. Y. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name David Lester

13. Birthplace New York.

MOTHER 14. Maiden name Louisa Brewer

15. Birthplace New York.

18. Informant Mrs Bessie L. Fletcher

Address 5061-1st St. Wash D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31 1946 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Md

18. Funeral director W. W. Chambers Co

Address 517-11th St SE. Wash. D.C.

19. Oct 28 1946 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946 at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1946 to October 28 1946

and that I last saw h alive on Oct. 28 1946

	DURATION
Immediate cause of death Cerebral Hemorrhage	about one Month
Due to Cardio-vascular-Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Roger S. Williams M.D.
M. D. or other

Address 35 New York Ave NW Date signed 10/28/46

RECEIVED
OCT 30 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-C)

12247

CERTIFICATE OF DEATH

Reg. Dist. No. 4140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 hrs
Hospital, institution, or street address where death occurred: Cedarcroft Sanitarium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hortense Melgar

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown 1901

8. AGE: Years	Months	Days	If less than one day
45	?	?	hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace "

MOTHER
14. Maiden name: "
15. Birthplace "

16. Informant: Wm. Henry Gittings
Address: 4619 R St., N. E., Kenilworth, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1946 (month) (day) (year)
Cemetery ~~or crematory~~: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Dec 28 1946 (Date rec'd by registrar) Josephine McHaeffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/24/ 1946 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... Autopsy 19...

Immediate cause of death	DURATION
Cerebral edema	
Due to: acute alcoholism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: Aut. Spec. sent to Slade Pathologoy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? —

23. SIGNATURE: J. M. Bird MD
Attending Pathologist M. D. or other
Address: Sandy Spring, Md. Date signed 10/24/46

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

The delay in burial and in depositing this death certificate was due to protracted investigation by the State's Attorney for Montgomery County, Maryland.

RECEIVED
JAN 2 1947
BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10158

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one day
Hospital, Institution, or street address where death occurred:
U.S.N.H. Bethesda Maryland
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 541 11th St. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd World War

3.(a) FULL NAME: MITCHELL, Fred Wilhott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	single

6.(b) Name of ~~husband or wife~~: brother Charles Mitchell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22 1902

8. AGE: Years	Months	Days	If less than one day
44	3	4	hrs. min.

9. Birthplace: Tenn
(Town, county, and state)
10. Usual occupation: VAP
11. Industry or business
FATHER 12. Name: Thomas Mitchell
13. Birthplace
MOTHER 14. Maiden name: Moolie Johnson
15. Birthplace: Tenn.
16. Informant: Brother: Charles Mitchell
Address: Greenville, Tenn.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 30, 1946 (month) (day) (year)
Cemetery or crematory: Veterans Administration Center Cemetery
Location: Mountain Home, Tennessee
18. Funeral director: W.W. CHAMBERS,
Address: 3072 "M" St. N.W. Wash., D.C.
19. Oct 28 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 Oct 1946, at 2245 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 October 1946, to 26 October 1946 and that I last saw him alive on 26 October 1946

Immediate cause of death	DURATION
Thrombosis, coronary artery	10 hr.
Due to arteriosclerosis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: massive coronary Thrombosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson C.W. THOMPSON Lt. Cmdr. (MC) NR
M. D. or other
Address: U.S.N.H. Bethesda, Md. Date signed: 28 Oct' 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10/30/46

RECEIVED
OCT 31 1946
BUREAU V 6

10159

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Suburban Hospt. Old Georgetown Rd.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: 5415 Lincoln St. Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5415 Lincoln St.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: JAMES LENLY MORRISON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie E.

Deceased — 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1853

8. AGE: Years	Months	Days	If less than one day
93	6	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Talbott Morrison
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Rebecca Mumper
15. Birthplace: Unknown

16. Informant: Jas. W. Morrison
Address: Son- Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1946 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director:
Address: 7557 Wis. Ave. Bethesda, Md.

19. 10/9 19.. Mrs E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 7 1946 and that I last saw him alive on 10-6-46 19..

Immediate cause of death	DURATION
Uremia	5 days
Due to: Urinary bladder abstruction	20 yrs.
Due to: Prostatic Hypertrophy	
Other conditions: Hypertension, Arteria-sclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward Colpoff, M.D.
M.D. or other

Address: 3921 Ingomar St. Wash. D.C. Date signed 10-8-46

OCT 10 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

Reg. Dist. No. 10169 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney / Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 17 hours -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 4 - Aspin Hills

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bernard Conneen Murphy

3.(b) Social Security Number 577-24-9530

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Mrs. Jean Murphy

6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) December 1st. 1922

8. AGE: Years 23 | Months 10 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Silver Spring, Maryland (Town, county, and state)

10. Usual occupation Bricklayer.

11. Industry or business

FATHER 12. Name Bernard Conneen Murphy

13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Helen Gertrude Barnes

15. Birthplace Silver Spring, Md

16. Informant Hospital records.

Address OLNEY. MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT. 10 - 1946 (month) (day) (year)

Cemetery or crematory ARLINGTON NATIONAL

Location ARLINGTON Co. VA.

18. Funeral director Warner E. Pumphrey

Address SILVER SPRING, MD.

19. 10-8- 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

(Burial permit issued by Silver Spring Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 11:54 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dept. med. Exam Can 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Massive collapse of lung - Rt. sided thoracic hemorrhage	18 hrs.
Due to Cerebral edema Shock.	
Due to Auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Dead on arrival

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-6-46

Where did injury occur? Aspin Hills - (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Bronchart M.D. Dept. Med. Exam M. D. or other

Address Gaithersburg Md Date signed 10-7-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
OCT 18 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (949)

CERTIFICATE OF DEATH

10161

Reg. Dist. No. 714

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Cooke Nursery

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Mont'g

City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)

Street No.: 24 Decatur St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME JOSEPH MUSCATELLO ~~Joseph Mustel~~

3.(b) Social Security Number 235-09-1300

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Frances

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 16th. 1882

8. AGE: Years	Months	Days	If less than one day
64	8	13	... hrs. ... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Retired (Landscape & Tree

11. Industry or business: Surgery

FATHER

12. Name: Philip Muscatello

13. Birthplace: Italy

MOTHER

14. Maiden name: Frances unknown

15. Birthplace: Italy

16. Informant: Mrs. Joseph Muscatello

Address: 24 Decatur St. Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-1-1946 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Oct 31 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1946, at 1:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam Case 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work? ...

23. SIGNATURE Frank J. Broschart M. D. — Dep. Med. Exam. (M. D. or other)

Address: Gaithersburg, Md. Date signed: 10-29-46

I

T

VS A15 9-45-1

RECEIVED
NOV 4 1946
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10162

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred: Diamond and Meem Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Diamond and Meem Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Eugene Marshall Nichols

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single - Divorced

6.(b) Name of husband or wife: Beatrice Baker Nichols

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6 1890

8. AGE: Years: 56 Months: 3 Days: 24 If less than one day: hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Real Estate Agent

11. Industry or business: Real Estate

FATHER 12. Name: George Nichols

13. Birthplace: Montgomery Co. Md.

MOTHER 14. Maiden name: Frances Faithful

15. Birthplace: Washington, D.C.

16. Informant: Alan Nichols

Address: Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/46 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg, Md.

18. Funeral director: E. E. Gartner

Address: Gaithersburg, Md.

19. Oct. 30 1946 (Date rec'd by registrar) Rhuda H. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1946 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Oct 30 1946 and that I last saw him alive on October 30 1946

Immediate cause of death	DURATION
Coronary Occlusion	2 hours
Due to: Hypertensive Heart disease	4 years
Due to: Hypertension	6 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilbur Welch, M.D.

M. D. or other

Address: Rockville, Md. Date signed: 10/30/46

RECEIVED
NOV 4 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10163

Reg. Diat. No. 714

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? June 15, 1946.
Hospital, Institution, or street address where death occurred:
Jolliff Nursing Home
How long in hospital or institution? June 15- 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2400 - 16th
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Owen, Daisy H.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Senator Robert L. Owen
6.(c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr.) January 25 - 1865

8. AGE: Years 81 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Atoka County Oklahoma (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name George Hester
13. Birthplace Oxford - N. Caro

MOTHER
14. Maiden name Elizabeth Fulton
15. Birthplace Macon, Ga.

16. Informant Mrs. Dorothea Whittemore
Address 2400 - 16th

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-30-46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md.
18. Funeral director Joseph Gawler's Sons
Address 1776 Penna Ave. N.W.
19. Oct 29 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946 to Oct 28 1946
and that I last saw h... on/alive on Oct 28 1946

	DURATION
Immediate cause of death Arteriosclerosis	
with Psychosis and Coronary Heart	6 Mo.
Due to disease	
Due to	
Other conditions Epilepsy	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Herbert J. Brown M.D.
M. D. or other
Address 45 Carroll Ave. Takoma Pk. Date signed Oct 29 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

RECEIVED
NOV. 4 1946

Evidence for the change of age is shownon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

FILM No. I 07 OCT 18 1946

10164

Reg. Diat. No. 714

1. PLACE OF DEATH

County Montgomery County

City or town Silver Spring Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery County

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Dale Drive

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary Audrey Payne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife Arthur R. Payne

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Dec 28 1899

8. AGE: Years	Months	Days	If less than one day
46	47		hrs. min.

9. Birthplace Cincinnati Ohio (Town, county, and state)

10. Usual occupation Instructor

11. Industry or business U. S. Government

FATHER 12. Name Arthur E. Stokes

13. Birthplace Ohio

MOTHER 14. Maiden name Jeannette Musgrove

15. Birthplace Ohio

16. Informant Gladys E. Kruse

Address 403 Dale Drive

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 15 1946 (month) (day) (year)

Cemetery or crematory

Location South Charleston Ohio

18. Funeral director W. W. Chambers Co.

Address Riverdale Md.

19. Oct 14 1946 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1946 at 9:40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Oct 1946 to 14 Oct 1946 and that I last saw h. on alive on 14 Oct 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	7 days
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Auf M.D. M. D. or other

Address 9506 Colesville Rd Silver Spring, Md Date signed 14 Oct 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

RECEIVED
OCT 16 1946
BUREAU V. M.

Evidence for the addition of middle name and birthplace of parents is shown on FILM No. I 08 OCT 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10165

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? From 9/26/41
Hospital, institution, or street address where death occurred: Cedarcroft Sanitarium
How long in hospital or institution? From 9/26/41

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington (formerly)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MARY ~~LINCOLN~~ Louise (CHASE) PAYNE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: George W. Payne
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): February 1, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	21	hrs. min.

9. Birthplace: District of Columbia (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: William H. Chase
FATHER 13. Birthplace: New York. N.Y.
MOTHER 14. Maiden name: Margaret E. Lincoln
MOTHER 15. Birthplace: Washington, D.C.
16. Informant: Mrs. G.W. Stretton
Address: 2044 N. Kenmore Arlington Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-46 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Arlington County Va.
19. Funeral director: W W Chambers & S
Address: 3072 M St N.W.
19. Oct 27 1946 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1946, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 26 1941 to Oct. 22 1946 and that I last saw h.. alive on Oct. 21 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions: Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Richard B. Whitehead M.D. M. D. or other
Address: Cedarcroft Sani., Silver Spg. Md. Date signed 10-22-46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

RECEIVED
OCT 24 1946
BUREAU V S

10166

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 28 days
Hospital, Institution, or street address where death occurred:
N.N.M.C. Bethesda, Maryland
How long in hospital or institution? 1 month 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Georgia County:
City or town: Rt.#1, Box 10, Midville, Ga.
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2.

3.(a) FULL NAME: PEARCE, Fred Junior

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1923

8. AGE: Years	Months	Days	If less than one day
23	6	25	hrs. min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: Fred Pearce (dec.)
13. Birthplace: Ga.

MOTHER
14. Maiden name: Merellae Cobb (dec.)
15. Birthplace: Ga.

16. Informant: brother: Mr. Arthur J. Pearce
Address: Rt. #1, Box 10, Midville, Ga.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 10-11-46 (month) (day) (year)
Cemetery or crematory: Bark Camp Cemetery
Location: Waynesboro, Georgia
18. Funeral director: Ernest W. Jarvis
Address: 1132 U St., N.W., Wash., D.C.

19. 11 October 1946 (Date rec'd by registrar) Mary Elizabeth Smith M.E. SMITH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 October 1946 at 0740 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 1946 to Oct. 11 1946 and that I last saw him alive on 11 Oct. 1946

Immediate cause of death	Sickle cell anemia	
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.:
Autopsy results: Sickle cell anemia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. L. Jones, Jr. H. L. JONES, Jr., Comdr. (MC) USNR M. D. or other
Address: USNH Bethesda, Md. Date signed: 10-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 19 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10167

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
601 Woodside Parkway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 601 Woodside Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: KATHERINE C. POZOSKA

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Alfred
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 23rd. 1890

8. AGE: Years	Months	Days	If less than one day
55	10	9	hrs. min.

9. Birthplace: Linc, Austria (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Peter Schauzmeyer
13. Birthplace: Austria

MOTHER
14. Maiden name: Marie Hictzinger
15. Birthplace: Austria

16. Informant: Mr. Alfred Pazoska
Address: 601 Woodside Parkway Sil. Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-4-1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince Georges Co.,
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. Oct 3 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 Oct 1946, at 5:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Oct 1946 to 2 Oct 1946 and that I last saw h... on ... alive on 1 Oct 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William D. Aud M.D.
M. D. or other
Address: Silver Spring, Md. Date signed: 2 Oct 46

M

I

V

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10168

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg 2nd Rural R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six Weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg Md. R.F.D. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Forest W Prather

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6. 1946

8. AGE: Years	Months	Days	If less than one day
	1	10	hrs. min.

9. Birthplace Gaithersburg Md (Town, county, and state)
10. Usual occupation None
11. Industry or business None

FATHER
12. Name Forest F Prather
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden name Blanch W Ross.
15. Birthplace Montgomery Co Md

16. Informant Blanch W Prather
Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16-1946 (month) (day) (year)
Cemetery or crematory Brooke Grove Md
Location Laytonsville Md

18. Funeral director Roy W Barber
Address Laytonsville Md

19. 10/16 1946 L O Bell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 - 1946, at 11.15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 6 1946, to Oct 15 1946
and that I last saw h alive on Oct 15 1946

Immediate cause of death	DURATION
Broncho-pneumonia	2 days
Due to (no attending physician)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockett M. D. - M. D. or other
Address Gaithersburg Md Date signed 10-16-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 22 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Dist. No. 10168 714

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15

1. PLACE OF DEATH:
County 10306 Loraine Av.
City or town Silver Sp. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Silver Sp. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10306 Loraine Av.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry T. Richards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Florence B. Richards
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1884

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace Williamsburg, Mass.
(Town, county, and state)
10. Usual occupation Govt. Clerk
11. Industry or business
FATHER 12. Name Frank C. Richards
13. Birthplace
MOTHER 14. Maiden name Emma L. Tilton
15. Birthplace Goshen, Mass.
16. Informant Florence B. Richards
Address 10306 Loraine Ave., Silver Spring, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/27/46 (month) (day) (year)
Cemetery or crematory
Location Williamsburg, Mass.
18. Funeral director The D. W. Stuntz Co.
Address 2901 - 14 St NW
19. Oct 28 19 46 Josephine McSchaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1946, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15th 1942, to Oct 25th 1946; and that I last saw h alive on Oct 24th 1946.

	DURATION
Immediate cause of death Cardiac Dilatation & Hypostatic pneumonia	24 hours
Due to Arterio Sclerosis	5 yrs
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. C. Mayhew M. D. or other
Address 1801 Eye St. Date signed Oct 25 '46


RECEIVED
OCT 30 1946
BUREAU V R

10170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 days
Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland
How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1635 U. St. S.E. Washington, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME
RICKER, Frank (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W US	married

6.(b) Name of husband or wife: Wife: Anna Sophie Ricker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3 Feb., 1879

8. AGE: Years	Months	Days	If less than one day
67	8	27	hrs. min.

9. Birthplace: Fla.
(Town, county, and state)

10. Usual occupation: VAP

11. Industry or business

FATHER
12. Name: — — —
13. Birthplace: Germany

MOTHER
14. Maiden name: — — —
15. Birthplace: Naches, Fla.

16. Informant: Mrs. Anna Sophie Ricker
Address: 1635 U. St. S.E. Washington, D.C.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 2, 1946
(month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. CHAMBERS
Address: 517 Eleventh St., S.E., Wash., D. C.

19. Oct. 30, 1946
(Date rec'd by registrar)
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 46 at 1407P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28 19 46, to Oct. 30 19 46
and that I last saw him alive on October 30 19 46

	DURATION
Immediate cause of death: Congestive heart failure.	weeks
Due to: Coronary art sclerosis and cerebral arteriosclerosis	years
Due to: generalized art sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: (No Autopsy) generalized art sclerosis.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson
C.W. THOMPSON, Lt. Cmdr. (MC) USNR
M. D.
Address: USNH Bethesda, Md.
Date signed: 10-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
NOV 4 1946
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

★ 10171

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

Horners Lane

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Fauquier

City or town: Catlett

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: John Wesley Rines Jr.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 17, 1905

8. AGE: Years	Months	Days	If less than one day
41-41	3	10	— hrs. — min.

9. Birthplace: Fauquier Co., Va. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: —

FATHER

12. Name: John Wesley Rines Sr.

13. Birthplace: Fauquier Co., Va.

MOTHER

14. Maiden name: Mary Abel

15. Birthplace: Prince Wm. - Va.

16. Informant: Mrs. Minnie Posey (sister)

Address: Prince Wm. - Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10/28/46 (month) (day) (year)

Cemetery or crematory: Catlett - Va.

Location: Catlett - Va.

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda - Md.

19. 10/28/46 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/27/ 1946 at 3.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. EXAM CASE 19..

and that I last saw ... alive on Postmortem 19..

Immediate cause of death	DURATION
Broncho-pneumonia	2
Due to: Coronal Occlusion	Sudden death
Due to: Cerebral Edema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: Above, Spec sent to State College

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: [signature] approved Pathologist M. D. or other

Address: Sandy Spring, Md. Date signed: 10/29/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 2 1946
BUREAU OF M.

10172

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Loudoun
City or town: Oatlands
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Constance Contre Ritticor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Chas F. Ritticor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 20 1859

8. AGE: Years: 87 Months: 4 Days: 1 If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: John Rust Carter
13. Birthplace: Va

MOTHER
14. Maiden name: Maria Smith
15. Birthplace: Va

16. Informant: F. H. Duncan
Address: Sandy Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-46 (month) (day) (year)
Cemetery or crematory: Leesburg
Location: Leesburg, Virginia

18. Funeral director: Lloyd Slack
Address: Leesburg, Loudoun Co. Va.

19. 10-22-1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/22/ 1946, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/20/ 1946, to 10/22/ 1946
and that I last saw h.e alive on 10/22/ 1946

	DURATION
Immediate cause of death: Acute cardiac dilatation	2 hrs.
Due to: Chronic Myocarditis	10 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Md Date signed 10/22/46

RECEIVED
NOV 6 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

★ 10173

Reg. Dist. No. 723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 12 mo - 20 mi

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 327 Flower Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rawell Mr. Benton Rufus

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 19, 1855

8. AGE: Years	Months	Days	If less than one day
91	0	10	4 hrs. 20 min.

9. Birthplace Orange, Vermont

(Town, county, and state)

10. Usual occupation Gardener

11. Industry or business

FATHER 12. Name Adolphus Rawell

13. Birthplace Bradford, Vermont

MOTHER 14. Maiden name Anne Thurber

15. Birthplace Windsor, Vermont

16. Informant Chart record & Hospital

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1946. (month) (day) (year)

Cemetery or crematory Fra Wash Mem. Cem.

Location Riggs Rd. Hyattsville Md.

18. Funeral director Arthur Walters.

Address 254 Carroll St. N.W. Wash D.C.

19. Oct 30 1946 (Date rec'd by registrar) William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1946, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941, to Oct 30. 1946.

and that I last saw him alive on Oct. 29 1946

Immediate cause of death	DURATION
Congestive Cardiac Failure	1 month
Due to Arteriosclerosis	4 years.
Due to	
Other conditions Cellulitis, R. foot.	2 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Stare M.D. M. D. or other

Address Takoma Park, Md. Date signed 10/30/46

RECEIVED
NOV 2 1946
BUREAU P.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

10174

Reg. Dist. No. 3-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 - Dartmouth Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John A. Sartain

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 19 - 1889

8. AGE:

Years	Months	Days	If less than one day
57	7	22	..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Fireman Retired.

11. Industry or business

FATHER

12. Name Wm B Sartain

13. Birthplace D.C.

MOTHER

14. Maiden name Elizabeth Wilson

15. Birthplace Wilkesbarre Pa.

16. Informant Wm Sartain (Son)

Address 511 - Dartmouth Ave Silver Spg

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1946 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Washington D.C.

18. Funeral director Albert Gable

Address 641 - H St NE. Washington D.C.

19. Oct 11 1946 (Date rec'd by registrar) Josephine M. Shaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-13- 1944, to Oct 11 1946

and that I last saw him alive on Oct 10 1946

Immediate cause of death	DURATION
Hypertensive heart disease	2 yrs.
Due to Hypertension & kidney (nephritis)	2 yrs +
Due to	
Other conditions Cerebral hemorrhage 11-44.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John N. Andrews M.D. M. D. or other

Address Silver Spring Md Date signed Oct 11-46

RECEIVED
OCT 14 19[illegible]
BUREAU F. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10175

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Irving Place
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SCHAEFER, Howard Emory

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Cora Schaefer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 18 August 1897

8. AGE: Years	Months	Days	If less than one day
49	1	29	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER
12. Name: Louis Schaefer
13. Birthplace: Md. (dec)

MOTHER
14. Maiden name: Mattie Crauch
15. Birthplace: Md. (dec)

16. Informant: wife: Mrs. Cora Schaefer
Address: 10 Irving Place, Pikesville, 8 Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: October 21, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore, National

Location: Baltimore, Md.

18. Funeral director: Newell Funeral Home

Address: Pikesville, Md.

19. 10-17, 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 October 1946, at 7:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 October 1946, to 17 October 1946 and that I last saw him alive on 17 October 1946

	DURATION
Immediate cause of death: cerebral hemorrhage	4 days
Due to: Hypertensive Heart disease	12 yrs.
Due to:	
Other conditions: Bronchopneumonia	2 days.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: cardiac hypertrophy, multiple thrombi, Central Newsom

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson Lt. Cdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15K

10/29/46

RECEIVED
OCT 31 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

CERTIFICATE OF DEATH

★10176

Reg. Dist. No. 2170

2 (M) (I) (T) VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery

City or town: Ashton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Ashton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen R. Shoemaker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: J. Janney Shoemaker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 8, 1859

8. AGE: Years	Months	Days	If less than one day
86	11	23.	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Housewife

11. Industry or business

FATHER — 12. Name: Henry Reese

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary A. Miller

15. Birthplace: Maryland.

16. Informant: Miss Clarice Shoemaker

Address: Ashton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2 1946 (month) (day) (year)

Cemetery or crematory: Pinda Cemetery

Location: Sandy Spring, Md.

18. Funeral director: Warren E. Pumphrey

Address: Silver Spring Md.

19. Nov. 2 1946 (Date rec'd by registrar) Gertrude K. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1946, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15/46 to 10/31/46 and that I last saw h[illegible] alive on 10/30/46

Immediate cause of death	DURATION
Uremia	3 days
Due to: Acute Cholecystitis	10 days
Due to: Senility	3yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? —

23. SIGNATURE: [illegible] M. D. or other

Address: Sandy Spring, Md. Date signed: 10/7/46

RECEIVED
NOV 6 1946
BUREAU U.S.
1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

10177

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: RURAL BETHESDA.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours 30 min.

Hospital, institution, or street address where death occurred:
SUBURBAN HOSPITAL GEO. RD.

How long in hospital or institution? 4 hours 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: BROOKMONT
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6417 POTOMAC DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME ~~Baby Girl~~ Lorraine Ellen Shuff

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

B.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1946

8. AGE: Years	Months	Days	If less than one day
			4 hrs. 30 min.

9. Birthplace: MONTOMERY RURAL BETHESDA.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: HORACE SHUFF

13. Birthplace: Mayland

MOTHER 14. Maiden name: GERRDINE MASSEY

15. Birthplace: WASHINGTON D.C.

16. Informant: Horace Shuff

Address: 6417 Potomac Drive Brookmont MD

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct 15 1946 (month) (day) (year)

~~Cemetery~~ or crematory: Suburban Hospital

Location: Bethesda, 14 MD

18. Funeral director: A B. Solon, Supt

Address: Bethesda 14 MD

19. 10/18 1946 (Date rec'd by registrar) Wm E Sellers Registrar

MEDICAL CERTIFICATION

40

20. DATE OF DEATH: 10-13 1946, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1946, to Oct. 13 1946

and that I last saw h e x alive on Oct. 13 1946

Immediate cause of death	DURATION
Maninigeal Hemorrhage,	
Extensive Hemorrhage in Ventricles	
of Brain and over base of brain.	
Due to	
Due to	
Other conditions: Aspiration Stomach contents - beginning Hemorrhagic Pneumonia; Atelectasis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bradley D Hodgkins MD
M. D. or other

Address: 313 W Bradley Lane Date signed: 10/13/46

RECEIVED
OCT 22 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

10178

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: 1508 Ballard St.
County Montgomery
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1832 Kilbourne Place, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Helen Hausta Skinner

3. (b) Social Security Number

4. Sex	5. Color or race	6. Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1878

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Aaron A. Skinner
13. Birthplace Mass.
MOTHER 14. Maiden name Sarah Gibbs
15. Birthplace Mass.
16. Informant Miss Alice Higgs
Address cousin
17. burial (Burial, cremation, or removal. Which?) Date thereof Oct 19, 46 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Washington, D.C.
18. Funeral director The S. H. Hines Co.
Address 2901 14th St. N.W. Wash, D.C.
19. Oct 19 (Date rec'd by registrar) 19 46 Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 19 46 at 5-10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 45 to Oct 17 19 46
and that I last saw h[illegible] alive on Oct 12 19 46

Immediate cause of death	DURATION
acute myocarditis	1 da
Due to cardio-vascular renal disease	3 yrs
Due to arterio sclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. E. Quayle M.D. M. D. or other
Address 1832 Kilbourne Place N.W. Washington D.C. Date signed 10/17/46

RECEIVED
OCT 21 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10179

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours.
Hospital, Institution, or street address where death occurred:
10 Maryland Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick (If outside city or town limits, write RURAL and give nearest town)
Street No.: Cor W. Patrick & South Market (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Hench Eyza Marcellus Smith

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	W

6.(b) Name of husband or wife: Hester Irene Feaga
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years 65 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace: Frederick County, Md. (Town, county, and state)
10. Usual occupation: Harness Maker
11. Industry or business:

FATHER
12. Name: Charles D. Smith
13. Birthplace: Frederick County Maryland

MOTHER
14. Maiden name: Eliza Warrenfeltz
15. Birthplace: Washington County Maryland

16. Informant: Sherwood F. Smith
Address: Gaithersburg, Md.

17. 10/11/46 (Burial, cremation, or removal. Which?) Date thereof: Burial (month) (day) (year)
Cemetery or crematory: M. R. Elchman & Son
Location: Frederick Md.

18. Funeral director: Burial Zion Reformed Cem.
Address: Charlesville, Md.

19. Oct. 9 1946 (Date rec'd by registrar) Alveda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1946, at 12 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1945, to Oct 8 1946
and that I last saw h. alive on Oct 8 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Hypertension	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gaithersburg, Md. Date signed: Oct 9 1946

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
OCT 12 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10184

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hrs. - 57 min.

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 15 hrs. - 57 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. Frankford, Delaware

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME ~~Baby Girl~~ Teresa Diane Stevens #2

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 25, 1946.

8. AGE: Years	Months	Days	If less than one day
			15 hrs. 57 min.

9. Birthplace: TAKOMA PARK, Maryland (Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER

12. Name: Guy Thomas Stevens

13. Birthplace: Chapel Hill, N.C.

MOTHER

14. Maiden name: Ida Jeannette Cohen

15. Birthplace: Chicago, ILL.

16. Informant: Washington Sanitarium + Hospital

Address: Takoma Park, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct 26-46 (month) (day) (year)

Cemetery or crematory: Lees Cremationinn

Location: Wash. D.C.

18. Funeral director: J. W. Lee Sons

Address: 300 - 4½ St N.E.

19. Oct 26 1946 (Date rec'd by registrar) J. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1946, at 5-45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1946, to Oct 25 1946

and that I last saw her alive on Oct. 25, 1946

Immediate cause of death	DURATION
Premature Birth	
Due to Seventh Month of Gestation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wallace H. Mook M.D. (M.D. or other)

Address: Takoma Park 12 Md Date signed: 10-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
OCT 30 1946
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

* 10181

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 942 Cameron St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Laurie Stickley

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Morgan B. Stickley (deceased)
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1861

8. AGE: Years	Months	Days	If less than one day
85	1	6	____ hrs. ____ min.

9. Birthplace: Port Republic, Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: John Waller Palmer
13. Birthplace: ?

MOTHER
14. Maiden name: Ann Harrison
15. Birthplace: Port Republic

16. Informant: Miss Elizabeth Stickley (daughter)
Address: 942 Cameron St., S. S., Md.

17. Removal Burial. (Burial, cremation, or removal. Which?) Date thereof: Oct - 30 - 1946 (month) (day) (year)
Cemetery or crematory: Spring-Hill
Location: Lynchburg - Campbell Co - Va

18. Funeral director: Manner & Pumphrey -
Address: Silver Spring - Md

19. Oct 29 1946 (Date rec'd by registrar) Josephine M. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Oct 1946, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 28 Oct 1946 and that I last saw h... alive on 25 Oct 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William D. Arul M.D. (M. D. or other)
Address: 9006 Colesville Rd Silver Spring Date signed: 28 Oct 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 30 1946
BUREAU

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

FILM No. I 08 NOV 15 1946

CERTIFICATE OF DEATH

1018

Reg. Dist. No. 2-18

1. PLACE OF DEATH:
~~County~~ Seneca, Md.
City or town Montgomery County
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rfd. Germantown, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Thomas Thrasher

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Esther Annie Thrasher
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec - 21 - 1888

8. AGE: Years	Months	Days	If less than one day
57 ~~58~~	9	10	— hrs. — min.

9. Birthplace Gramlah, Md.
(Town, county, and state)
10. Usual occupation day-labor
11. Industry or business odnors and Sundry
FATHER 12. Name William F. Thrasher
13. Birthplace Va.
MOTHER 14. Maiden name Mary Goodman
15. Birthplace Cumberland, Md.
16. Informant Esther Annie Thrasher
Address Germantown, Md. R-2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/46 (month) (day) (year)
Cemetery or crematory Germantown Cemetery
Location Germantown Md.
18. Funeral director E. E. Gaither
Address Gaithersburg Md.
19. Oct 3 1946 (Date rec'd by registrar) Abbie L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 2 - 1946 at 2 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 24 - 1946 to Oct - 2 - 1946 and that I last saw h. alive on Oct - 2 - 1946

Immediate cause of death	DURATION
Tuberculosis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Hiller, M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 10/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 5 1946
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10183

Reg. Dist. No. 223

1. PLACE OF DEATH:
County 1000 Carroll Av., Montgomery
City or town Takoma Pk Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1000 Carroll Ave
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Takoma Pk. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1000 Carroll Av.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alexander Turnbull

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Elizabeth D.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31- 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace Dunfarmline, Scotland
(Town, county, and state)

10. Usual occupation Plasterer

11. Industry or business

FATHER 12. Name Andrew Turnbull
13. Birthplace Scotland

MOTHER 14. Maiden name Florence Rogers
15. Birthplace London, England

16. Informant Mrs. Elizabeth Turnbull
Address 1000 Carroll Ave., Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-25-1946 (month) (day) (year)
Cemetery or crematory George Washington Memorial Cemetery
Location Prince Georges County, Md.

18. Funeral director The O. H. Hines Co
Address 2901-14 St N.W.

19. Oct-25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct 24 1946 at 11:34 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1946 to Oct. 24 1946
and that I last saw him alive on Oct. 24 1946.

	DURATION
Immediate cause of death Coronary thrombosis	Sev. months
Due to	
Due to	
Other conditions Myocarditis	Sev. months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place, (where?)
Means of injury Injured at work?

23. SIGNATURE Raymond Hazen M.D.
M. D. or other
Address Date signed 10-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
OCT 26 1946
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-D

CERTIFICATE OF DEATH

10184

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, is especially important. Physicians: please write the causes of death clearly and legibly. The correct age

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 45 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No. River Road
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME Raymond William Twyman

3.(b) Social Security Number 212-16-0346

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Blanche
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1918.

8. AGE: Years 27 | Months 11 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Herndon, Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Frank Twyman
13. Birthplace Va.

MOTHER 14. Maiden name Rose Jones
15. Birthplace Va.

16. Informant wife
Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13 1946 (month) (day) (year)
Cemetery or Crematory Scaggsville
Location Scaggsville, Md.

18. Funeral director Robert L. Sprowden
Address 246 N. Wash. St. Rockville

19. 10/12 1946 Mrs E Johns Reg
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 10 - 1946, at 5-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Intra-cranial hemorrhage	1¼ hrs.
Due to fracture of Skull (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 10-10-46
Where did injury occur? Bethesda (City or town) Monty (County) Md. (State)
Injured at home, farm, industry, public place (where?) Woods
Means of injury Struck by falling Tree Injured at work? Yes

23. SIGNATURE Frank J Bouchat M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md Date signed 10-19-46

RECEIVED
OCT 15 1946
BUREAU V. S.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

10185

Reg. Dist. No. 2, 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Boyd - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montg

City or town: Boyd R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME J. Paul Wade

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Courtney B Wade

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June - 24 - 1898

8. AGE: Years: 46 Months: 3. Days: 10 If less than one day: hrs. min.

9. Birthplace: Boyd - Montg. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Marcellus Wade

13. Birthplace: Md

MOTHER 14. Maiden name: Laurie Young

15. Birthplace: Md

16. Informant: Eugene Wade

Address: Boyd - RFD - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 6 - 46 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md

18. Funeral director: William B Hilton

Address: Barnesville, Md

19. Oct. 5 1946 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. A. W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1946, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1946, to Oct 4 1946

and that I last saw h alive on Oct 4 1946

Immediate cause of death	DURATION
Hemorrhage	Found dead at home
Due to: Gastric ulcer	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.

Dep. Med. Exam. · M. D. or other

Address: Gaithersburg Md Date signed: 10 - 4 - 46

RECEIVED
OCT 9 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

10180

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 yr., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7005 Rowling Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: WAESCHE, Russell Randolph, Admiral USCG Ret. Inactive

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Agnes R. Waesche

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 6, 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	9	11		

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER

12. Name: Leonard Randolph Waesche

13. Birthplace:

MOTHER

14. Maiden name: Forman

15. Birthplace:

16. Informant: Wife: Mrs. Agnes R. Waesche

Address: 7005 Rowling Road, Chevy Chase, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-21-46 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: S. H. Hines Company

Address: 2901-03-05-07 14th St., N. W., Wash., D. C.

19. 10-17 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 October 1946 at 1:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Oct. 1945 to 17 Oct. 1946

and that I last saw him alive on 17 Oct. 1946

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to: metastatic carcinoma - generalized	10 mo
Due to: Adenocarcinoma of Sigmoid colon	2 yrs
Other conditions: Pleural effusion, Hydrothorax, Hepatic edema, ascites	6 mo

(Include pregnancy within 3 months of death)

Coronary Heart Disease and arteriosclerosis 15-16 mo

Major findings of operations: Adenocarcinoma of Sigmoid colon Date of op. 3-1-45

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Cuthbert Owens Lt Cdr (MC) USNR M. D. or other

Address: USNH Bethesda Md Date signed: 10/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a

10187

Reg. Dist. No. 29

1. PLACE OF DEATH:

County: Montgomery County

City or town: Silverdon (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4118 - 30th Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary J. Wallingsford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1877

8. AGE: Years: 69 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fredericksburg
(Town, county and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Asbury Meade Wallingsford
13. Birthplace: Spotsylvania, Va.

MOTHER
14. Maiden name: Mary J. Wallingsford
15. Birthplace: Spotsylvania, Va.

16. Informant: Edward E. Cissell

Address: 4118 - 30th St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Maryland

18. Funeral director: Wm. J. Malley

Address: 3200 - Rhode Island Ave. Mt. Rainier, Md.

19. Oct. 10 19 46 (Date rec'd by registrar) Charles E. Fisher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 19 46 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 19 46 to October 10 19 46 and that I last saw her alive on October 3 19 46

Immediate cause of death	DURATION
(a) Thrombosis of Coronary Arteries	3 weeks
Due to: Generalized Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Albert K. John M.D. M. D. or other

Address: Poolesville, Md. Date signed: Oct 10 - 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

OCT 15 1946
BUREAU F.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10188

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 11 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland

How long in hospital or institution? 1 month 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1618 4th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd World War

3.(a) FULL NAME: WATERS, James (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	col.	married

6.(b) Name of husband or wife: Mrs. Mary Waters

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-14-05

8. AGE: Years	Months	Days	If less than one day
41	4	11	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: VETERAN

11. Industry or business: laborer

FATHER — 12. Name: UNKNOWN

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: UNKNOWN

MOTHER — 15. Birthplace:

16. Informant: Wife: Mrs. Mary Waters
Address: 1618 4th St., N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-29-46 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Henry S. Washington & Sons

Address: 467 N Street NW, Washington, D.C.

19. 10-25-46 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 Oct. 19 46, at 1242 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 19 46, to October 25 19 46 and that I last saw him alive on October 25 19 46

Immediate cause of death	DURATION
Carcinomatosis	2 mos
Due to Carcinoma of Stomach	2 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W.A. DINSMORE, Lt. Cmdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Maryland Date signed: 10-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10/30/46

RECEIVED
OCT 31 1946
BUREAU V.R.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

10189

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
226 Cedar Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 226 Cedar Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: JOSEPH MILTON WELSH

3. (b) Social Security Number: 147-07-4201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Maude K.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 21st. 1889

8. AGE: Years	Months	Days	If less than one day
57	6	22	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Saleaman
11. Industry or business: Food

FATHER
12. Name: Warner G. Welsh
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Knox
15. Birthplace: Maryland

16. Informant: Mrs. Maude K. Welsh
Address: 226 Cedar Ave. Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince Georges Co., Md.
18. Funeral director: Hamer E. Humphrey
Address: Silver Spring, Md.

19. Oct 17 1946 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 October 1946, at 10 13 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Sept. 1946, to 13 Oct. 1946
and that I last saw him alive on 13 Oct. 1946

Immediate cause of death	DURATION
Cardiac Failure	7 Days.
Due to: Coronary Disease	14 Days.
Due to: Arterio Sclerosis, Hypertension.	Few years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: None performed. Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H B Queen M.D.
M. D. or other
Address: 112 Willow Ave. Takoma Park, Md. Date signed 13 Oct 46

RECEIVED
OCT 17 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

10190

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D C County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Van Buren St NW
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary L White

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William White
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 24, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	10	1		

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Angus Lammond
13. Birthplace: Dunfermline Norway

MOTHER
14. Maiden name: Alcena Cunnan
15. Birthplace: Lisbon Ohio

16. Informant: William White
Address: 110 Van Buren St NW

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 25 1946 (month) (day) (year)
Cemetery or crematory: Washington Rock Creek
Location: D C
18. Funeral director: Neal Funeral Home
Address: 4812 Ga Ave N.W. D.C.

19. 10-25-46 (Date rec'd by registrar) N E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 October 1946, at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 July 1946 to Oct. 25 1946
and that I last saw her alive on 25 October 1946

Immediate cause of death	DURATION
Coronary Thrombosis	9 days.
Due to: Hypertension Heart Disease	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: None Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H B Queen M.D.
M. D. or other
Address: Takoma Park. Md Date signed: 25 Oct 1946.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 ✓

RECEIVED
OCT 29 1945
BOREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 912

CERTIFICATE OF DEATH

★ 10191

Reg. Dist. No. 22-3

Copy

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15½ yrs

Hospital, institution, or street address where death occurred:
Emergency Room

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 Maple Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Susan Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	Married

6.(b) Name of husband or wife Charles E. Williams

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 1, 1893

8. AGE:

Years	Months	Days	If less than one day
63		23	hrs. min.

9. Birthplace Grafton, Virginia
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business own home

FATHER 12. Name Charles Hopkins

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Eliza Chandler

MOTHER 15. Birthplace Virginia

16. Informant Emily Williams - daughter

Address 718 Maple Ave. Takoma Pk.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 26, 1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D.C.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. N.W. Takoma Pk. D.C.

19. Oct 24 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 46, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3rd 1946 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos J. Bouchart M.D. M. D. or other

Address Gaithersburg Md Date signed Oct. 24, 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 26 1946
BUREAU V. S.

10192

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days 19 hrs
Hospital, Institution, or street address where death occurred: Washington San + Hosp. Takoma Park, Md.
How long in hospital or institution? 8 days 19 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Louden
City or town Purcellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Franklin Pope Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth Wilson
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1857

8. AGE: Years 88 | Months 9 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Fairfax County, Virginia
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business —

MOTHER FATHER
12. Name Isaac Wilson
13. Birthplace ? Maryland

MOTHER
14. Maiden name Theodate Pope
15. Birthplace Baltimore Maryland

16. Informant Hospital Records
Address Washington Sanitarium + Hosp.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 22, 1946 (month) (day) (year)

Cemetery or crematory —

Location PURCELLVILLE VIRGINIA.

18. Funeral director Joseph F. Bucks' Sons
Address 6034-36 Ga. Ave. N.W. Wash. DC

19. 10-22 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 12:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Oct 22 1946
and that I last saw h... alive on Oct 22, '46 1946

	DURATION
Immediate cause of death: Acute Congestive Failure	1 minute
Due to: Coronary Occlusion	1942
Due to: Arteriosclerosis	years
Other conditions: Diabetes Mellitus	years

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D.
M. D. or other
Address Takoma Park, Md. Date signed 10/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
OCT 25 1946
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10193

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Usual street address where death occurred:
104 Hodges Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Hodges Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: JOSEPH DAVID WILSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

8.(b) Name of husband or wife: Rose E.

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 28th. 1895

8. AGE: Years	Months	Days	If less than one day
51	1	19	hrs. min.

9. Birthplace: Westminister, Maryland
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: U. S. Goverment

FATHER
12. Name: Henry J. Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna E. Lynch
15. Birthplace: Maryland

16. Informant: Mrs. Rose E. Wilson

Address: 104 Hodges La. Takoma Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-19-1946 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D.C.

18. Funeral director: Farmer Funeral Service

Address: Silver Spring, Md.

19. Oct 18 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 October 1946 at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Oct. 1946, to 17 Oct. 1946 and that I last saw him alive on 17 Oct. 1946

Immediate cause of death	DURATION
Coronary Occlusion with myocardial infarction	31 hrs.
Due to Coronary Artery disease	2 yrs.
Due to Arteriosclerosis	3-4 years
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: H B Queen M.D.
M. D. or other

Address: Takoma Park, Md. Date signed 18 Oct 1946.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 19 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

★ 10194

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Gaithersburg. Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr 6 Mo
Hospital, institution, or street address where death occurred:
1Yr 6 Mo
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg,
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillie M, Wrightson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jeremiah S Wrightson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22 1865

8. AGE: Years	Months	Days	If less than one day
1865 81	6	0	..... hrs. ..... min.

9. Birthplace: Baltimore. Md,
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: " "

FATHER
12. Name: James C Shelling
13. Birthplace: Md,

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Methodist Home, M M Wilson
Address: Gaithersburg, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/46 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg. Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19. Oct. 23 1946 (Date rec'd by registrar) Alvin G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 46 11P m (19..... at ..... M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July — 1946, to Oct - 22 - 1946 and that I last saw her alive on Oct - 21 - 1946

Immediate cause of death	DURATION
exhaustion, mania	3 mo
Due to: Organic dementia	
Due to: Cerebral arteriosclerosis (Revised to read)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William D. Miller, M.D. M. D. or other
Address: Gaithersburg, Md, Date signed 10/23/46

RECEIVED
OCT 28
PORT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

10195

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: 8408 Piney Branch Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8408 Piney Branch Court
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Zschiegner. Mr. Roland Carl

3.(b) Social Security Number: 221-01-7886

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Helen W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1st. 1900

8. AGE: Years	Months	Days	If less than one day
46	0	4	..... hrs. ..... min.

9. Birthplace: Wellsville, N. Y. (Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business: Briggs Filtration Co.
FATHER 12. Name: Emil Zschiegner
13. Birthplace: Germany
MOTHER 14. Maiden name: Elizabeth Hennecke
15. Birthplace: Wellsville, N. Y.
16. Informant: Mrs. Helen W. Zschiegner
Address: 8408 Piney Branch Courts
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 8th. '46 (month) (day) (year)
Cemetary or crematory: Fort Lincoln Cemetery
Location: Prince Georges Co., Md.
18. Funeral director: Warner E. Pumphrey, m
Address: Silver Spring, Md.
19. Oct 7 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 5 - 1946, at 11 55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-11-1941, to 10-3-1946 and that I last saw h.. liv.. alive on 10-3-1946

Immediate cause of death	DURATION
Acute coronary occlusion	25 minutes
Due to: Generalized arteriosclerosis	10 years
Due to: previous tendency to clot excessively easy -	8 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: M. Schumaker M.D. M. D. or other
Address: 8005 Woodbury Dr - Silver Spring, Md. Date signed: 10/6/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 9 1945
BUREAU V S